Patient Name:_____

DOB:_____ Wt(kg):_____

Allergies:_____ Phone:_____

CEREZYME (IMIGLUCERASE)
INFUSION ORDERS

****REQUIRED INFORMATION****

☐ This signed order form from the provider
☐ Patient demographics & insurance information
☐ **Clinical/Progress Notes** supporting primary diagnosis

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis:

☐ Gaucher Disease (ICD-10: _____)

CEREZYME ORDERS

Patient Weight: _____kg

☐ 60 units/kg IV every 2 weeks

☐ Other Dosage:_____

Premedications: ☐ Tylenol 1000 mg PO
☐ Benadryl 25 mg PO
☐ Solumedrol _____mg
☐ Other: _____

Prescriber to monitor for antibody formation during 1st year of treatment.

****Once we receive all necessary documentation, we will schedule the patient's treatment.**

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	