6111 Burnet Rd.
Austin, TX 78757
Phone: 512.454.9923
Fax: 512.454.9866

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:	