Cerezyme (IMIGLUCERASE)
Infusion Orders

REQUIRED INFORMATION

- This signed order from the provider
- Patient demographics & insurance information
- Clinical/Progress notes supporting primary diagnosis

Patient Name:	DOB:
Allergies:	Patient Phone:

Diagnosis:

- Gaucher Disease (ICD-10: ___________)

- Cerezyeme 60 Units/kg IV every 2 weeks
- Other dosage: ____

Premedications:
- Tylenol 1000 mg PO
- Diphenhydramine 25 mg PO
- Solu-Medrol ________________ mg
- Other: __________________

Prescriber to monitor for antibody formation during first year of treatment.

Additional Instructions:

Physician Name:	Phone:	Fax:

Physician Signature:	Date: