ELAPRASE (IDURSULFASE)
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:

- ☐ Hunter Syndrome (ICD-10: _____)

J Code: J1743

Patient weight: _____ kg

Elaprase 0.5 mg/kg IV every week
Premedications 30 minutes prior to infusion (unless contraindicated):

- ☐ Tylenol 1000 mg PO
- ☐ Diphenhydramine 25 mg PO

Additional instructions:

Physician Name:	Phone:	Fax:

Physician signature:	Date: