



Nucara Pharmacy Nucara Infusion Center
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 Austin, TX 78757 Austin, TX 78757
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 Fax: 512-524-1801 Fax: 512-524-1801

Patient Name: _____

DOB: _____ Wt(kg): _____

Allergies: _____ Phone: _____

VPRIV (Velaglycerase Alfa) Infusion Orders

Required Information:

Signed order from prescribing provider
 Patient demographics including insurance information
 Supporting clinical documentation: Visit notes, diagnostic results

Primary Diagnosis:

Gaucher Disease(ICD-10 : _____)
 Other: _____(ICD-10: _____)

VPRIV ORDERS

VPRIV 60 units/kg every other week

Date of last VPRIV: _____

VPRIV _____ units; frequency: _____

Administered per manufacturer guidelines

PRE-MEDICATIONS

PO Tylenol _____ mg

PO Loratadine _____ mg

PO Cetirizine _____ mg

PO IV Diphenhydramine _____ mg

IV Solu-medrol _____ mg

PO IV Other: _____ mg

LABS

CBC

ESR

Uric Acid

Frequency:

Every Visit

CMP

TB Quantiferon Gold

Other: _____

Every Other Visit

CRP

Hep B Core/Surface AG

Other: _____

One time only

Other: _____

CPL Acct #: _____

ADDITIONAL INSTUCTIONS

Please include accommodations to be made for the patient, catheter care, prn orders, etc.

Physician Name:	Phone:	Fax:
Physician Signature:	NPI:	Date: