Lysosomal Storage Disorder
Patient Referral

225 Route 46 West Suite 3
Totowa, NJ 07512
Phone: 973-837-6877
Fax: 973-837-6878

client information

patient: _____ (last name, first name) male female DOB: _____ SS#: _____

address: _____ (street, city, state, zip)

primary phone number: _____ cell alternate phone number: _____ cell

caregiver: _____ allergies: _____ NKDA

comorbidities: _____ height: _____ lbs kg weight: _____ date: _____

diagnosis

Diagnosis/I CD-9:

272.7 Gaucher Disease
272.7 Fabry Disease
271.0 Pompe Disease
277.5 Mucopolysaccharidosis I (MPS I)
277.5 Mucopolysaccharidosis II (MPS II, Hunter Syndrome)
277.5 Mucopolysaccharidosis VI (MPS IV, Maroteaux-Lamy Syndrome)
Other: _____ (ICD 9 or ICD 10 code and description)

prescription

Aldurazyme®	2.9 mg vial	Dose: _____ mg units intravenously
Cerezyme®	400 unit vial	Volume to infuse: _____
Elaprase®	6 mg vial	Frequency: _____
Fabrazyme®	5 mg vial 35 mg vial	Rate (ml): _____ rate titration required
Lumizyme®	50 mg vial	
Myozyme®	50 mg vial	
VPRIV®	200 unit vial 400 unit vial	# of doses: _____ refills: _____
Cerdelga™	84 mg capsule	Take 84 mg capsule once twice daily by mouth. # of doses: _____ refills: _____

prescriber + shipping information

prescriber (print): _____ office contact: _____

preferred method of contact: phone fax email preferred contact persons email: _____

ship to: patient office alternate _____ (street, suite, city, state, zip)

office address: _____ (street, suite, city, state, zip)

phone: _____ fax: _____ N PI: _____ DEA: _____

prescriber's signature: _____ date: _____

insurance information: please fax copy of insurance card (front + back)

updated on 08/05/15

patient information

patient: _____ (last name) _____ (first name) male female DOB: _____

nursing agency assigned: _____

nursing coordination required? yes no-patient already trained no-nursing already coordinated

Spanish-speaking nurse or interpreter service required? yes no

pre medications

Hydration prior to during following infuse: _____ ml _____ solution

Diphenhydramine_____ _____ mg 30 min before infusion PO IVP

Acetaminophen _____ _____ mg 30 min before infusion PO

Solu-cortef® _____ mg slow IVP

Solu-Medrol® _____ mg slow IVP pre halfway upon completion

Other: _____

line care (per protocol)

Dressing change, access and cleansing:

Delivery Method — Vascular Device

PIV

Central: _____

flush orders (per protocol)

0.9% Sodium Chloride 5-10 mL	Heparin _____ ml (_____u/mL) as SASH

nursing assessment

Skilled nursing visit to: establish IV access, administer medication as prescribed, provide patient education related to disease state/ therapy, assess general status and response to therapy. Frequency determined by therapy schedule

Obtain baseline vital signs

Monitor vital signs per protocol

Provide needles, syringes, VAD and other ancillary supplies required for safe infusion.

Discontinue use and notify prescribing physician if patient demonstrates any of the following:
Fluid overload, cardiovascular symptoms, allergic reaction, moderate/severe headac he, s/sx Aseptic Meningitis

Procedure for Anaphylaxis (pharmacy to provide):

1. Stop Infusion

2. Call 911 and prescribing physician immediately

3. Adminster the following (per protocol):
   Diphenhydramine 25-50 mg slow IV/IM Q 4 hours PRN, dispense (1) 50 mg vial
   Epinephrine (1:1000) 0.4 mg subcutaneously PRN, dispense 1 vial
   0.9% Sodium Chloride 500 mL, use as directed, dispense 1 bag

Prescriber's signature: _____/ _____ date:_____

I authorize Diplomat Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. (sign DAW for no substitutions)