ameripharma SPECIALTY CARE

Lysosomal Storage Disorder

Phone: 877-778-0318 Fax: 877-778-0399

PATIENT INFORMATION

Patient Name: _____ ☐ Male ☐ Female DOB: _____ SS#: _____

Address: _____

Primary Phone#: _____ ☐ cell ☐ home Alt Phone #: _____ ☐ cell ☐ work

Caregiver: _____ Allergies: _____

Comorbidities: _____ Height: _____ Weight: _____ ☐ lbs ☐ kg Date: _____

DIAGNOSIS

☐ 272.7 Gaucher Disease

☐ 272.7 Fabry Disease

☐ 271.0 Pompe Disease

☐ Other: _____

☐ 277.5 Mucopolysaccharidosis I (MPS I)

☐ 277.5 Mucopolysaccharidosis II (MPS II, Hunter Syndrome)

☐ 277.5 Mucopolysaccharidosis VI (MPS IV, Maroteaux-Lamy Syndrome)

INSURANCE INFORMATION

Insurance Plan Name: _____ Insurance Phone: _____

Policy Number: _____ Group#: _____ RxBin#: _____ RxPCN#: _____

please fax copy of insurance card (front and back)

PRESCRIPTION

☐ **Aldurazyme®**	☐ 2.9 mg vial	
☐ **Cerezyme®**	☐ 400 unit vial	
☐ **Elaprase®**	☐ 6 mg vial	
☐ **Fabrazyme®**	☐ 5 mg vial	☐ 35 mg vial
☐ **Lumizyme®**	☐ 50 mg vial	
☐ **Myozyme®**	☐ 50 mg vial	
☐ **VPRIV®**	☐ 200 unit vial	☐ 400 unit vial

Dose: _____ ☐ mg ☐ units intravenously

Volume to infuse: _____

Frequency: _____

Rate (mL): _____ ☐ rate titration required

# of doses: _____ refills: _____

☐ **Cerdelga™** ☐ 84 mg capsule

Take 84 mg capsule ☐ once ☐ twice daily by mouth

# of doses: _____ refills: _____

PRESCRIBER INFORMATION

Prescriber's Full Name: _____ Office Contact: _____

DEA #: _____ State License #: _____ NPI #: _____

Preferred Method of Contact: ☐ phone ☐ fax ☐ email Preferred contact's email: _____

Office Address: _____

Phone #: _____ Fax #: _____

Prescriber's Signature: _____ Date: _____

By signing above, I authorize Ameripharma and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

SHIPPING INFORMATION

Ship to: ☐ patient ☐ prescriber's office ☐ alternate

Address: _____

Lysosomal Storage Disorder
CONTINUED

NURSING INFORMATION

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

_____ mg 30 min before infusion ☐ PO ☐ IVP

☐ Diphenhydramine _____

_____ mg 30 min before infusion PO

☐ Acetaminophen _____

☐ 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 headache, s/sx Aseptic Meningitis

Procedure for Anaphylaxis (pharmacy to provide):

1. Stop infusion
2. Call 911 and prescribing physician immediately
3. Administer 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 AmeriPharma and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

(sign DAW for no substitutions)