AYSA
THERAPEUTICS INFUSION CENTER

CEREZYME (IMIGLUCERASE) ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

Diagnosis: Gaucher Disease ☐ ICD-10 Code: _____

☐ Other: _____ ICD-10 Code: _____

Patient Weight: _____ lbs.

Allergies: _____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

CEREZYME ORDERS

Cerezyme ☐ Dose: 60mg/kg IV every 2 weeks

☐ Other Dosage: _____

Protocol: ☐ Tylenol 1000mg PO

☐ Benadryl 25 mg PO

☐ Solumedrol _____ mg

☐ Other: _____

Prescriber to monitor for antibody formation during 1st year of treatment.

****Once we receive all necessary documentation, we will schedule the patient's treatment.**

Additional Orders/Comments:

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc*. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Physician Name: _____ Date: _____

Phone: _____ Fax: _____ Contact Person: _____