AYSA
THERAPEUTICS INFUSION

VPRIV (VELAGLUCERASE ALFA FOR INJECTION) 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: __________

Patient Weight: __________ lbs.

Allergies: ______________________________

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

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

Lab Orders: ______________________________

VPRIV ORDERS

☐ Dose: 60U/kg IV administered every two weeks as a 60 minute infusion

☐ Other: ________ U IV every two weeks as a 60 minute infusion

Pre-Medications (optional):

☐ Acetaminophen ________ mg PO before infusion

☐ Diphenhydramine ________ mg PO/IV before infusion

☐ Solu-medrol ________ mg IV before infusion

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: ______________

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