MIC | METRO INFUSION CENTER

INFUSION ORDERS-CEREZYME (IMIGLUCERASE)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

*List of infusion center locations may be found at: https://metroinfusioncenter.com/infusion-center-locations/
Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE	
☐ Type I Gaucher Disease	ICD 10 Code: E75.22

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider ☐ Patient demographics AND insurance information ☐ Beta-glucosidase leukocyte (BGL) Enzyme Test Results	☐ Clinical/Progress notes ☐ Labs and Tests supporting primary diagnosis
Please indicate if your patient's disease has caused any of the following, *check all that apply*: ☐ Anemia ☐ Moderate to Severe Hepatosplenomegaly ☐ Skeletal Disease ☐ Thrombocytopenia (Plt ≤ 120,000) ☐ Symptomatic Disease (bone pain, fatigue, dyspnea, angina, abdominal distention, or diminished QOL)	

MEDICATION ORDERS	
Dosing	☐ Cerezyme 60 units/kg IV every 2 weeks** ☐ Cerezyme _____ units/kg IV_____ ** (Dosing ranges from 2.5 units/kg given 3 times per week to 60 units/kg given every 2 weeks)
Patient's Most Recent Weight = _____ kg	
Refills: ☐ X 6 months ☐ X 1 year ☐ _____ doses (all doses including initial loading)	

** Patient weight is required for all weight-based orders.

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

Contact us with questions at: BioNurses@MetroInfusionCenter.com or call (877) 448-3627
Fax completed form and all documentation to (866) 507-1164
All information contained in this form is strictly confidential and will become part of the patient's medical record.