

ELAPRASE

Please include the following to expedite the order:

Patient Demographics, Insurance Information, Labs

PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Name: _____ DOB: _____ Gender: ☐ M ☐ F ☐ Other _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

PRESCRIBER

Name: _____ DEA: _____ NPI: _____ State License: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

CLINICAL

Diagnosis: ☐ E76.1 (Mucopolysaccharidosis type II) ☐ E76.3 (Mucopolysaccharides, unspecified)

Allergies: _____ Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in

CBC Completed: ☐ Yes ☐ No CMP/LFTs Completed: ☐ Yes ☐ No

TREATMENT

ELAPRASE (idursulfase)

Route: Intravenous infusion

Dose: ☐ 0.5mg/kg

Frequency:

☐ Once weekly

Premedication Protocol:

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO

☐ Other: _____

Sig: _____

☒ Center will use anaphylactic and hypersensitivity protocol established by Restore Health

Special Instructions: _____

Quantity: _____ Refills: _____

Provider Signature: _____

Date: _____

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments. Thank you.