

ELAPRASE

Please include the following to expedite the order:
Patient Demographics, Insurance Information, Labs

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____ Gender: ☐ M ☐ F ☐ Other _____
Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA: _____ NPI: _____ State License: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

CLINICAL INFORMATION

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 INFORMATION

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: _____

Special Instructions: _____

Quantity: _____ Refills: _____

Provider Name: _____ Provider Signature: _____ Date: _____

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