

ELELYSO

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: ☐ E75.22 (Gaucher disease)

Allergies: _____ **Weight:** _____ ☐ Kg ☐ Lbs **Height:** _____ ☐ cm ☐ in

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

TREATMENT INFORMATION

ELELYSO (taliglucerase alfa)

Route: Intravenous infusion

Dose: ☐ 60units/kg (treatment-naïve)

☐ ___ units/kg (switching from imiglucerase)

If previously on a stable dose of imiglucerase, patients are recommended to begin treatment with Elelyso at the same dose.

Premedication Protocol:

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

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

☐ Methylprednisolone: ☐ 40mg ☐ 125mg IV

☐ Other: _____

Sig: _____

Frequency:

☐ Every other week

Quantity: _____ **Refills:** _____

Special Instructions: _____

Provider Name: _____ **Provider Signature:** _____ **Date:** _____

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