

Lysosomal Storage Disorders REFERRAL FORM



FAX REFERRAL TO: +1(844) 277-0049

PHONE: +1(844) 650-5802

1 PATIENT'S INFORMATION (Complete or include demographic sheet)

Patient Name: _____ DOB: _____ Gender: MALE FEMALE
 Address: _____ City/State/Zip: _____
 Primary Phone: _____ Email: _____ SSN: _____ Primary Language: _____
 Emergency Contact: _____ Relationship to Patient: _____ Phone: _____

2 INSURANCE (Please attach **IF AVAILABLE** a copy of the Patient's insurance card(s) Front/ Back)

Primary Insurance: _____ Policy No: _____ Group: _____
 Primary RX Insurance: _____ ID No: _____ RX GRP: _____ RX BIN: _____ RX PCN: _____

3 DIAGNOSIS AND CLINICAL INFORMATION

First time receiving Therapy? Yes No If No, previous product used: _____ Last Dose Given: _____

Diagnosis (ICD-10):

- E74.02 Pompe Disease: Infantile Onset Late Onset
- E75.21 Fabry Disease: Exhibiting clinical signs/symptoms? YES NO
- E75.22 Gaucher Disease: Type 1 Type 2 Type 3 **CYP2D6 Genotype:** Ultra Rapid Extensive Intermediate Poor
- E75.24 Niemann-Pick disease, acid sphingomyelinase deficiency (ASMD)
- E75.5 Other Lipid Storage Disorders E76.0 Mucopolysaccharidosis I (MPS I) E76.1 Mucopolysaccharidosis II (MPS II, Hunter Syndrome)
- E76.219 Mucopolysaccharidosis IVA (MPS IVA, Morquio A Syndrome) E76.29 Mucopolysaccharidosis VI (MPS VI, Maroteaux-Lamy Syndrome)
- Other Code: _____ Description: _____

Patient Clinical Information:

Drug Allergies: _____ NKDA Ht: _____ in/cm Wt: _____ lbs/Kg

Labs: Please fax copy of the following labs dated within 1 year of the patients referral request:

- CMP CBC w/ diff Iron/TIBC panel Ferritin

4 PRESCRIPTION INFORMATION

ACCESS: IV PORT

RX INFORMATION: Our pharmacist will identify clinically appropriate brand *(Unless product is specifically specified at the time of referral)* and infusion rate per FDA guidelines. Clinically appropriate substitutions may be allowed based on availability or payor requirements. Round dose(s) to the nearest vial size. Official orders will be outlined with "May Infuse" +/- 3 days if scheduling needs arises, with insurance payor approval".

PRODUCT: Aldurazyme Cerezyme Elaprase Eleyso Fabrazyme Kanuma Lumizyme Naglazyme Nexviazyme
 Vimizim Vpriv Xenpozyme Other: _____

DOSE & DIRECTIONS		FREQUENCY
<input type="checkbox"/>	Dose _____ mg _____ mg/kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL	_____
<input type="checkbox"/>	Ramping Required	
<input type="checkbox"/>	Dose _____ Units _____ Units / kg Body Weight, IV Vol to infuse _____ mL Rate _____ mL	_____
<input type="checkbox"/>	Ramping Required	

ANAPHYLAXIS PROTOCOL:

MEDICATION	DIRECTION	QUANTITY	REFILLS
<input checked="" type="checkbox"/> EPINEPHRINE (vial or autoinjector)	Administer IM for severe anaphylactic reaction. May repeat in 5-15 minutes <input type="checkbox"/> 0.3 mg (Wt > 30 kg) <input type="checkbox"/> 0.15 mg (Wt 15-30 kg) <input type="checkbox"/> 0.1 mg (Wt 7.5-15 kg)	Quantity: (x1) Vial OR (x2) Pen(s)	Refills: PRN
<input checked="" type="checkbox"/> DIPHENHYDRAMINE (50mg/mL)	Administer via IM or slow IV push for severe anaphylactic reaction. <input type="checkbox"/> 50 mg (Wt > 30 kg) <input type="checkbox"/> 25 mg (Wt 15-30 kg) <input type="checkbox"/> 12.5mg (Wt 7.5-15kg)	Quantity: (x1) Vial(s)	Refills: PRN

NURSING/ LABS/ INFUSION SUPPLIES:

- NURSING:** Nursing visits with each infusion to establish venous access, administer medication, assess and monitor patient, provide education, and complete lab draws.
- INFUSION SUPPLIES:** Diluent, infusion supplies, and infusion pump PRN for the reconstitution, administration, and disposal of medication.
- FLUSHING PROTOCOL:** Infusion Line (Post Enzyme). Flush line with up to 50 mL of Sodium Chloride 0.9% D5W, after completion of infusion.
 Sodium chloride 0.9%, up to 10 mL before/after medication, and/or PRN to maintain patency.
 Heparin: 10 Units/mL 100 Units/mL, _____ as final flush and/or PRN to maintain patency
- LABS:** [Dx code: Z79.899, Other long term (current) drug therapy]. Note: Samples are time sensitive once drawn.
 Labs to be drawn every _____ months prior to administration: CBC w/ diff CMP Iron/TIBC panel Ferritin.

5 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

Prescriber Name: _____ Title: MD DO ND PA APRN NPI: _____
 Address: _____ City/State/Zip: _____
 Phone: _____ Fax: _____ Contact Person: _____

- DISPENSE AS WRITTEN BRAND MEDICALLY NECESSARY DO NOT SUBSTITUTE May Substitute / Product Selection Permitted / Substitution Permissible
- NO SUBSTITUTION / DAW / MAY NOT SUBSTITUTE

Prescriber's Signature: _____ Date: _____ Prescriber's Signature: _____ Date: _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution." NY & IA: electronic prescription required.

Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber.

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. I authorize IV Solutions RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions RX.
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THANK YOU FOR YOU TRUSTING US WITH YOUR PATIENTS SPECIALTY CARE

#welcome to our family