SPECIALTY INFUSION CENTER
An Access Infusion Care Company

CEREZYME (IMIGLUCERASE) ORDERS

PATIENT INFORMATION

Name: _____ DOB: _____ Height: _____ Weight: _____

Address: _____ Phone: _____ Allergies: _____

City, State, Zip: _____ Email: _____

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Is this the first dose? ☐ Yes ☐ No, date of last infusion: _____ Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other

DIAGNOSIS AND ICD-10 CODE

☐ Type I Gaucher Disease ICD-10 Code: _____

☐ Diagnosis: _____ ICD-10 Code: _____

REQUIRED DOCUMENTATION

☐ This signed order form by the provider

☐ Patient demographics AND insurance information

☐ Beta-glucosidase leukocyte (BGL) Enzyme Test Results

☐ H&P and Clinical/Progress notes supporting primary diagnosis

☐ 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 _____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)

Refills*: ☐ X 6 months ☐ X 1 Year ☐ Other: _____

**(if not indicated, order will expire 1 year from date signed)*

☐ RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline

☐ RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration

☐ RN to flush and lock VAD/CVAD per company protocol:

Other: _____

PREMEDICATION ORDERS

☐ Acetaminophen 650mg PO prior to infusion

☐ Diphenhydramine 25mg PO prior to infusion

☐ Other: _____

☐ Other: _____

EMERGENCY MEDICATIONS

☐ Administer the following medications as needed for infusion-related reactions per company protocol:

Adults (weight >40kg):

Diphenhydramine 25mg-50mg PO
Diphenhydramine 25mg-50mg slow IV push over 2-5 mins
Acetaminophen 325mg-650mg PO
Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.3mg IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Pediatrics (weight <40kg): (may adjust with weight changes)

Diphenhydramine 25mg PO
Diphenhydramine 25mg slow IV push over 2-5 mins
Acetaminophen 325mg PO
Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI Number: _____

Office Phone: _____ Office Fax: _____

Prescriber Signature: _____ Date: _____

REV: 6/2025

Gaylord, MI
Phone: (989) 619-6253
Fax: (855) 857-3834

Traverse City, MI
Phone: (231) 252-0893
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