Lysosomal Storage Disorder

Rx International Pharmacy

Phone: (305) 221-1421
Fax: (305) 221-3275

Client Information

patient: _____ (last name, first name) ☐ male ☐ female DOB: _____ SS#: _____

address: _____ (street, city, state, zip)

primary phone number: _____ ☐ cell alternate phone number: _____ ☐ cell

caregiver: _____ allergies: _____ ☐ NKDA

comorbidities: _____ height: _____ weight: _____ ☐ lbs ☐ kgs date: _____

Diagnosis

Diagnosis/ICD-9:

☐ 272.7 Gaucher Disease
☐ 272.7 Fabry Disease
☐ 271.0 Pompe Disease
☐ 277.5 Mucopolysaccharidosis I (MPS I)
☐ 277.5 Mucopolysaccharidosis II (MPS II, Hunter Syndrome)
☐ 277.5 Mucopolysaccharidosis VI (MPS IV, Maroteaux-Lamy Syndrome)
☐ Other: _____ (ICD 9 or ICD 10 code and description)

Prescription

☐ Aldurazyme®	☐ 2.9 mg vial	Dose: _____ ☐ mg ☐ units intravenously Volume to infuse: _____ Frequency: _____ Rate (ml): _____ ☐ rate titration required # of doses: _____ refills: _____
☐ Cerezyme®	☐ 400 unit vial	
☐ Elaprase®	☐ 6 mg vial	
☐ Fabrazyme®	☐ 5 mg vial ☐ 35 mg vial	
☐ Lumizyme®	☐ 50 mg vial	
☐ Myozyme®	☐ 50 mg vial	
☐ VPRIV®	☐ 200 unit vial ☐ 400 unit vial	
☐ Cerdelga™	☐ 84 mg capsule	Take 84 mg capsule ☐ once ☐ twice daily by mouth. # of doses: _____ refills: _____

Prescriber + Shipping Information

prescriber (print): _____ office contact: _____

preferred method of contact: ☐ phone ☐ fax ☐ email preferred contact persons email: _____

ship to: ☐ patient ☐ office ☐ alternate _____ (street, suite, city, state, zip)

office address: _____ (street, suite, city, state, zip)

phone: _____ fax: _____ NPI: _____ DEA: _____

prescriber's signature: _____ date: _____

I authorize Rx International Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Insurance Information: please fax copy of insurance card (front + back)

Patient Information

patient: _____ (last name) _____ (first name) ☐ male ☐ female DOB: _____

nursing agency assigned: _____

nursing coordination required? ☐ yes ☐ no-patient already trained ☐ no-nursing already coordinated

Spanish-speaking nurse or interpreter service required? ☐ yes ☐ no

Pre Medications

☐ Hydration ☐ prior to ☐ during ☐ following infuse: _____ ml _____ solution

☐ Diphenhydramine _____ _____ mg 30 min before infusion ☐ PO ☐ IVP

☐ Acetaminophen _____ _____ mg 30 min before infusion PO

☐ Solu-cortef® _____ mg slow IVP

☐ Solu-Medrol® _____ mg slow IVP ☐ pre ☐ halfway ☐ upon completion

☐ Other: _____

Line Care (per protocol)

Dressing change, access and cleansing:

Delivery Method — Vascular Device

☐ PIV

☐ Central: _____

Flush Orders (per protocol)

☐ 0.9% Sodium Chloride 5-10 mL

Heparin _____ ml (_____u/mL) as SASH

Nursing Assessment

☐ Skilled nursing visit to: establish IV access, administer medication as prescribed, provide patient education related to disease state/ therapy, assess general status and response to therapy. Frequency determined by therapy schedule

☐ Obtain baseline vital signs

☐ Monitor vital signs per protocol

☐ Provide needles, syringes, VAD and other ancillary supplies required for safe infusion.

☐ Discontinue use and notify prescribing physician if patient demonstrates any of the following:
Fluid overload, cardiovascular symptoms, allergic reaction, moderate/severe headache, s/sx Aseptic Meningitis

Procedure for Anaphylaxis (pharmacy to provide):

1. Stop Infusion
2. Call 911 and prescribing physician immediately
3. Adminster the following (per protocol):
   - ☐ Diphenhydramine 25-50 mg slow IV/IM Q 4 hours PRN, dispense (1) 50 mg vial
   - ☐ Epinephrine (1:1000) 0.4 mg subcutaneously PRN, dispense 1 vial
   - ☐ 0.9% Sodium Chloride 500 mL, use as directed, dispense 1 bag

Prescriber's signature: _____ **date:** _____

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