



## Enzyme Replacement Therapy Order Form

Select patient referral location:  Blue Ash  Worthington  Crestview Hills  Springfield  West Cincinnati  
Fax completed form to 888-977-0914. For new referrals, please include recent labs and last two office visit notes.

Toll Free Phone: 877-787-8720 • www.horizoninfusions.com

### 1. PATIENT INFORMATION

Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: <input type="checkbox"/> Lbs <input type="checkbox"/> Kg
Patient Status: <input type="checkbox"/> New to therapy <input type="checkbox"/> Continuing therapy <input type="checkbox"/> Next due date (if applicable):	

### 2. PHYSICIAN INFORMATION

Physician's name:	NPI#:
License #: <input type="text"/>	TIN#: <input type="text"/>
DEA#: <input type="text"/>	
Address: <input type="text"/>	
City: <input type="text"/>	State: <input type="text"/>
	Zip: <input type="text"/>
Office contact: <input type="text"/>	Email: <input type="text"/>
Office phone: <input type="text"/>	Office fax: <input type="text"/>

### 3. DIAGNOSIS INFORMATION (and year of diagnosis)

Type 1 Gaucher Disease  Fabry Disease  Pompe Disease  ICD 10 (  )  Other (specify):

### 4. INSURANCE INFORMATION

Please submit copies of the front and back or primary and secondary insurance cards with this referral.

### 5. PRESCRIPTION INFORMATION (requires new order every 12 months)

#### ENZYME REPLACEMENT THERAPY

Cerezyme  
 Administer 60U/kg IV q 2 weeks IV OR  
 Administer

Lumizyme  
 Administer 20 mg/kg IV q 2 weeks IV OR  
 Administer

Fabrazyme  
 Administer 1 mg/kg IV q 2 weeks IV OR  
 Administer

Vital signs per HI Protocol  
 Anaphylaxis & Hydration Management per HI Protocol

#### PRE-MEDICATIONS N/A

Acetaminophen  500mg  650mg  1000mg PO  
 Fexofenadine (Allegra) 180mg PO (or other non-sedating anti-histamine)  
 Diphenhydramine (Benadryl)  25mg  50mg  PO  IV (requires driver)  
 Methylprednisolone (Solu-Medrol)  40mg  80mg  125mg IV  
 Prednisone  mg PO  
 Other:

#### POST-MEDICATIONS N/A

Acetaminophen  500mg  650mg  1000mg PO  
 Prednisone  mg PO  
 Other:

### 6. LABS

<input type="checkbox"/> CBC w/Diff	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): <input type="text"/>
<input type="checkbox"/> CRP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): <input type="text"/>
<input type="checkbox"/> CMP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): <input type="text"/>
<input type="checkbox"/> ESR	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): <input type="text"/>
<input type="checkbox"/> Hepatic Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): <input type="text"/>
<input type="checkbox"/> Renal Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): <input type="text"/>
<input type="checkbox"/> Quantiferon TB Gold, annually, last completed (date): <input type="text"/>		
<input type="checkbox"/> Other (specify): <input type="text"/>		

### 7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE