

# CEREZYME (imiglucerase)

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Status:  New to therapy  Continuing  Next Due Date (if applicable)

## PROVIDER INFORMATION

Provider Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_  
 Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Practice Name: \_\_\_\_\_  
 Practice Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_

## MEDICAL INFORMATION

Patient Weight: \_\_\_\_\_ Patient Height: \_\_\_\_\_ ICD-10 Code (required): \_\_\_\_\_ ICD-10 Description: \_\_\_\_\_  
 Known Allergies: \_\_\_\_\_

### Required Labs:

## DETAILS NEEDED FOR AUTHORIZATION

- Proof of patient being concurrently treated with any other biologic: \_\_\_\_\_
- Prescriber to monitor for antibody formation during the first year of treatment.

## CEREZYME (imiglucerase) ORDERS

Dose:  60 mg/kg IV every 2 weeks  
 Other Dose:  \_\_\_\_\_  
 Protocol:  Tylenol 1000mg PO  
 Benadryl 25mg PO  
 Solumedrol \_\_\_\_\_ mg  
 Other: \_\_\_\_\_

**Additional Orders/Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## ADULT RESCUE MANAGEMENT PROTOCOL

*These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.*

- Following standing reaction orders, including diphenhydramine, methylprednisolone, albuterol, and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

## REQUIRED STANDARD DOCUMENTATION NEEDED

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| <ul style="list-style-type: none"> <li>• Patient demographics</li> <li>• Patient medical insurance card, copied front and back</li> <li>• Patient pharmacy card, copied front and back (if they have one)</li> </ul> | <ul style="list-style-type: none"> <li>• Most recent chart notes and if available, last history and physical. All relevant scans, tests and laboratory results.</li> <li>• If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.</li> </ul> |
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## PROVIDER AUTHORIZATION

Provider's Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_