

ELAPRASE (indursulfase)

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: _____
- **Patient must bring own Epi-Pen to each infusion**

ELAPRASE (indursulfase) ORDERS

Dose: 0.5 mg/kg IV every week
 Other Dose: _____ every: _____
 Pre-medications:
 Tylenol 1000mg PO
 Benadryl 25 mg PO given 30 minutes prior to infusion

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

- Patient demographics
- Patient medical insurance card, copied front and back
- Patient pharmacy card, copied front and back (if they have one)

- Most recent chart notes and if available, last history and physical. All relevant scans, tests and laboratory results.
- If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.

PROVIDER AUTHORIZATION

Provider's Signature: _____ Print Name: _____ Date: _____