

LAWRENCE COUNTY
Memorial  Hospital
DEACONESS ILLINOIS PARTNER

PATIENT INFORMATION		
Name:	DOB:	
Allergies:	Date of Referral:	
REFERRAL STATUS		
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal		
DIAGNOSIS AND ICDE 10 CODE		
<input type="checkbox"/> Type 1 Gaucher Disease ICD 10 Code: E75.22		
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)		
<input type="checkbox"/> The signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Prior authorization with reference number *Pt may be required to submit a pregnancy test prior to treatment	<input type="checkbox"/> Clinical/Progress notes (must be within 1 year) <input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> Beta- glucosidase leukocyte (BGL) Enzyme test results	
List tried and failed therapies including duration of treatment:		
1) _____ 2) _____ 3) _____		
Please indicate if you patient's' disease has caused any of the following, check all that apply:		
<input type="checkbox"/> Anemia <input type="checkbox"/> Moderate to severe Hepatosplenomegaly <input type="checkbox"/> Skeletal Disease <input type="checkbox"/> Thrombocytopenia <input type="checkbox"/> Symptomatic Disease (bone pain, fatigue, dyspnea, angina, abdominal distention or diminished quality of life)		
MEDICATION ORDERS		
Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____ **Pt wt required for weight-based orders		
Dosing:	<input type="checkbox"/> J1786 Cerezyme 60 units/kg IV every 2 weeks <input type="checkbox"/> J1786 Cerezyme _____ units/kg IV _____ (Dosing ranges from 2.5 units/kg given 3 times per week to 60 units/kg given every 2 weeks)	
Duration: <input type="checkbox"/> x6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> x _____ doses		
ADDITIONAL ORDERS/ INFORMAITON		
PRESCRIBER INFORMATION		
Provider Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:	Date:	Time:

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515
 FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

INFUSION ORDERS –CEREZYME (IMIGLUCERASE)