allianceRx Walgreens Pharmacy

Phone: 877-865-9035
Fax: 866-889-1667

Enzyme Replacement Therapy Referral Form

☐ New to therapy ☐ Therapy Continuation

Date Initiated: ______________ Date Needed: ______________

PATIENT INFORMATION

Full name ______________

Date of birth ______________ ☐ Male ☐ Female

Street address ______________

City ______________ State ______ Zip ______

Primary phone ______________ Secondary phone ______________

Patient's guardian ______________ HIPPA Consent ☐ Yes ☐ No

Insurance company ______________

Phone ______________

Insured's name ______________

Relationship to patient ______________

ID ______________ Group ______________

Does patient have secondary insurance? ☐ Yes ☐ No

PRESCRIBER INFORMATION

Prescriber's name ______________

State License ______________

NPI ______________ DEA # ______________

Address ______________

Phone ______________

Fax ______________

CLINICAL INFORMATION

Diagnosis code: ______________

Weight: ________ Height: ________ Date recorded: ______________

☐ NKDA ☐ Known drug allergies ______________

Previous Enzyme Replacement therapies (if applicable):

____

Please provide copy of primary and secondary insurance with this form

PRESCRIBING INFORMATION

☐ Aldurazyme 2.9mg/5mL
☐ Cerezyme 400 unit
☐ Elaprase 6mg/3mL
☐ Fabrazyme 5mg and/or 35mg

☐ Kanuma 20mg/10mL
☐ Lumizyme 50mg
☐ VPRIV 400 unit

Other
☐ ______________
(Specify Product)

Route: ☐ IV ☐ Other ______________
Dose: ______________ **Qty:** ________ **Refills:** ______ **Directions:** ______________

For home infusion patients only:
1. Pharmacy will calculate final infusion volume and rates suggested within manufacturer's package insert based on patient weight, unless otherwise specified.
2. Preferred final volume for administration (if applicable): ______________
3. Preferred infusion rates for administration (if applicable): ______________

IV access:
☐ Peripheral ☐ Port ☐ PICC

Flush Protocol:
Use 5mL to 10mL of 0.9% NaCl before and after each infusion. Sterile syringes required for PICC/PORT.
Maintain PICC with 3 to 5mL of 10unit/mL of heparin and maintain implanted port with 3 to 5mL of 100unit/mL of heparin.

Pre-medication:
☐ Acetaminophen 325mg tablets
Sig: Take two 325mg tablets (650mg) by mouth 30-60 minutes prior to infusion.
Qty: 2 per dose
☐ Diphenhydramine 25mg capsules
Sig: Take one to two 25mg capsules (25-50mg) by mouth 30-60 minutes prior to infusion.
Qty: 2 per dose

Medications to be used as needed:
☐ Lidocaine 2.5%/Prilocaine 2.5% Cream
Sig: Apply small amount to injection site 60 min prior to infusion
Qty: 1 tube
☐ Other Sig: ______________ Qty: ________

Pre/Post Hydration:
______ mL of ☐ 0.9% NaCl ☐ D5W ☐ before ☐ after ☐ concurrently at a rate of ______ mL/hour.
☐ Other: ______________

Anaphylxis Kit:
☐ Provide anaphylaxis kit per protocol (epinephrine 1 mg/mL ampule, diphenhydramine 50 mg/mL vial, diphenhydramine 12.5mg or 25mg tablets or capsules, 1000cc 0.9% NaCl, all infusion supplies)
☐ Epinephrine Pen 2-pack (0.3 mg for ≥30 kg; 0.15 mg for <30 kg) Sig: Inject IM in event of anaphylaxis Qty: 1 pack Refills: PRN

Nursing Care:
☐ Infused in office or infusion center ☐ Home Nursing needed
☐ Nursing already coordinated:
Agency ______________ Phone: ______________
☐ RN to provide home nursing services for administration of ERT and as needed for IV site care and complications related to therapy. ***Patient must be six months reaction free prior to utilizing home infusion care.***

Supplies: AllianceRx Walgreens Pharmacy will provide all supplies, ancillary equipment and fluids necessary for reconstitution, dilution and administration for home infusion.

Dispense (for all above): provide a 4-week supply or please specify if other: ______________
Refills (all above): 1-year supply OR ______________ (please specify)

Substitution Permissible. In order for a brand name product to be dispensed, the prescriber must handwrite "BRAND NECESSARY" or "BRAND MEDICALLY NECESSARY" in the space provided: ______________

Prescriber's Signature (Dispense as Written) ______________ **Date:** ______________

Prescriber's Signature (Substitution Permissible) ______________ **Date:** ______________

For ARNP, NP, and PA, collaborative physician agreement is with: ______________

***** THIS FORM IS NOT VALID IN THE STATE OF ALABAMA ***** CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. Drug names are the property of their respective owners.

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