elixir
SPECIALTY PHARMACY

Enzyme Replacement Therapy Enrollment Form
Phone: 877-437-9012 Fax: 877-309-0687

☐ New to Therapy
☐ Current Therapy

Patient Information

Patient Name: _____
Date of Birth: _____ Sex: M☐ or F☐ Caregiver: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail: _____
Please attach copy of front and back of patient's prescription ins. card(s) if applicable
Insurance Company Name: _____
Insurance Company Phone: _____
Policy holder: _____
Policy holder Employer: _____
Relationship to Patient: _____
ID# _____ Group# _____
RxBIN: _____ RxPCN: _____
Copay Card: _____

Prescriber Information

Practice/ Organization Name: _____
Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone#: _____ Fax#: _____
DEA# _____ NPI# _____
License#: _____ Medicaid UPIN#: _____
Physician Specialty: _____
Prior Authorization Information: ☐ Please fax PA forms ☐ PA started
☐ PA has been approved, auth #: _____
☐ Other: _____
Date Shipment Needed: _____
Ship to: ☐ **Patient** ☐ **Prescriber** ☐ **Other:** _____
Shipment Address: _____ Attn: _____
City: _____ State: _____ Zip: _____
If shipped to the prescriber's office,Prescriber accepts on behalf of patient for administration in office.
Current Nursing Agency or indicate if nursing needs set up: _____
_____

Clinical Information and Prescription

Primary Diagnosis (ICD10): ☐ _ _ _ . _ _ Description: _____
Secondary Diagnosis (ICD10): ☐ _ _ _ . _ _ Description: _____
Height: _____☐inches/☐cm Weight: _____☐lb/☐kg Date of Measurement: ___/____/_____
Allergies: _____
Has the patient tried and failed other products? ☐ Yes _____ ☐ No
Current Medications: _____
_____
Vascular Access: ☐ Peripheral IV ☐ Port-a-cath ☐ PIC ☐ Central line ☐ Other: _____
Administration by: ☐ Caregiver ☐ Nursing Agency ☐ Other: _____
Agency nurse to visit home for injection: ☐ No ☐ Yes: Agency Name / Phone:
_____
Date of First/Next Injection: ____/____/_____ **Date of Last Injection:** ____/____/_____
Pump: ☐ Need to rent from Elixir ☐ Patient owns a pump ☐ Other: _____

☐ **Enzyme Replacement Product:** ☐ Cerezyme ☐ Fabrazyme ☐ Elaprase ☐ Cerdelga

Directions: _____
Quantity: _____ **Refills Authorized**: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 6 ☐ 1 ☐ Other: _____
Infusion Rate: _____
Flush Protocol: _____
Ancillary medications:

Drug	Directions	Quantity	Refills
☐ **Diphenhydramine** ☐25mg ☐50mg	☐ Take ____mg po 30-60m prior to inf and q4-6hr prn. Maximum of 4 doses in 24 hours	☐ #10 ☐ QS ☐ ____	☐ 11 ☐ ___
☐ **Acetaminophen** ☐325mg ☐500mg	☐ _____		
☐ **Epinephrine** ☐ 0.3mg AI ☐ 0.15mg AI	☐ Inject IM into thigh p.r.n. anaphylaxis	☐ 2-pack	☐ 1 ☐ ___
☐ **NaCl 0.9% 10ml flush**	Flush line with 10ml, before and after infusion and prn for line care	☐ 28ds ☐ ____	☐ 11 ☐ ___
Other:			

Supplies requested: _____

X_____ **Date:** ____/____/____
Physician Signature (no stamps) **For No Substitution allowed, please indicate "DAW" here:**