

**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: \_\_\_\_\_

**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: \_\_\_\_\_

**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: \_\_\_\_\_

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

**Supplies requested:** \_\_\_\_\_

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