INTRAMED Plus
infusion services

VPRIV®

INFUSION & MEDICAL CENTER

1. Patient Name ______ **DOB** ______ **Patient Phone/Cell #** ______

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD-10 Code):

Primary Diagnosis: _____ Gaucher Disease ICD-10 Code: E75.22

_____ Other: ______________________________ ICD-10 Code: ______

Allergies: ____ (or attach list)

3. Clinical Information — Please fax with Infusion Order Form:

- Clinical Notes and Labs supporting primary diagnosis
- Medication List

Patient
Weight: _______ lbs.
Height ________ in.

4. Infusion Center — Lab Orders (Check Order for Infusion Center to Manage):

❏ Obtain Serum IgG Antibodies at baseline and every _________for the duration of therapy
❏ Obtain CBC, platelets, LFTs at baseline and every ____________ for the duration of therapy
❏ Other: ____

VPRIV® (velaglucerase alfa) J Code: J3385

5. Drug Order:

❏ Infuse 60 units/kg once every 2 weeks

❏ Alternative Dosing: ____

______ Refills (Recommend 26 Refills)

Pre-Medication Orders: ____

Antihistamines and/or corticosteroids not routinely used in clinical studies unless hypersensitivity reactions were observed

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing our services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: ______________________ / ______________________ Date: ____________
Dispense as written Substitution permitted

Printed Physician's Name with Credentials: ______________________ Phone #: ____________

FAX ALL INFORMATION CENTRAL FAX **803.999.1754**	**INFUSION CENTER LOCATIONS** BERKELEY CHARLESTON COLUMBIA GREENVILLE CENTRAL INTAKE PHONE 803.999.1760

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