Cumberland Vital Care
Fax Referral To:
(931) 456-4857
Direct Phone: (931) 456-0680

CEREZYME ORDER FORM

Date:	ICD-10 Code: _____
Patient Name:	Allergies: _____
Date of Birth:	Weight: _____lbs OR _____kg

Therapy Status	Provider Information
☐ New Start	Ordering Provider: _____
☐ Continuing Therapy:	Provider NPI: _____
Last Dose: _____	Provider Phone: _____
	Provider Fax: _____
	Provider Address: _____

MEDICATION ORDER

☐ Cerezyme	☐ Administer Cerezyme _____U/kg IV every _____ weeks per protocol. ☐ Administer Cerezyme _____U/kg IV _____ times per week per protocol.	Refills x one year from date of signature unless indicated below. ☐ _____ refills

PRE-MEDICATIONS

Oral	IV
☐ Acetaminophen: ___325mg ___500mg __650mg	☐ Dexamethasone: ___4mg ___8mg
☐ Loratadine: 10 mg	☐ Diphenhydramine: ___25mg __50mg
☐ Cetirizine: 10mg	☐ Famotidine: ___20mg ___40mg
☐ Diphenhydramine: ___25mg ___50mg	☐ Methylprednisolone 125mg
☐ Famotidine: ___20mg ___40mg	☐ Hydrocortisone 100mg
☐ Ibuprofen: ___200mg ___400mg ___600mg	☐ Ondansetron: ___4mg ___8mg
☐ Ondansetron: ___4mg ___8mg	☐ Other_____
☐ Other_____	

LAB ORDERS (Please indicate any labs to be drawn and frequency)	OTHER REQUIRED DOCUMENTATION
Surveillance lab ordering, and monitoring is the responsibility of the prescriber	(Please fax this signed order form, along with the following documents to 800-223-4063) • History & Physical, Last Ofice Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work

By signing below, I certify that above therapy is medically necessary Prescriber's Signature (SIGN BELOW)

Dispense as Written:	Substitution Allowed:
_____ _____ Prescriber Name Date	_____ _____ Prescriber Name Date

V 3.9.22