Fax: 1-877-405-7940
Phone: 1-800-486-2668

CenterWell Specialty Pharmacy

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Monday – Friday: 8 a.m. – 11 p.m. and
Saturday: 8 a.m. – 6:30 p.m. Eastern time

Remove above portion before faxing. Please complete the prescription form in its entirety and fax to the number above.

Lysosomal Storage Disorders Form

Patient Information

Patient:____________________________ ❒ Female ❒ Male DOB:__________ Insurance Plan:_________________ Plan ID #:____________

Address:____ City:__________________________ State:_____ Zip Code:_____________

Home Phone #:_______________ Cell Phone #:_______________ Caregiver:_____________________ Caregiver Phone #:_______________

Other Medical Conditions:______________________________ Allergies: ❒ No ❒ Yes:____

Height:______ Weight:_____ ❒ lb ❒ kg Date:________

Clinical Information

Diagnosis ICD10 ❒ Fabry Disease E7521 ❒ Gaucher Disease E7522 ❒ Hunter Syndrome E76.1 ❒ Hurler's Syndrome E76.01
❒ Lysosomal Alpha 1 Deficiency E74.02 ❒ Mucopolysaccharidosis VI (MPS-VI) E76.29 ❒ Pompe Disease E74.02
❒ Sanfilippo syndrome (Mucopolysaccharidosis III) E76.3 ❒ Scheie's Syndrome E76.03 ❒ Other:____

Additional PA ❒ New therapy ❒ Continuing therapy ❒ Investigational **First dose?** ❒ Yes ❒ No **Expected date of first/next infusion**:__________________

Venous access: ❒ Peripheral ❒ Port ❒ PICC ❒ CL: Type ___________ **Infuse via** ❒ PUMP ❒ Gravity as tolerated by patient ❒Other: ______________

❒ Skilled nursing visit to establish venous access, patient education related to therapy & disease state, administer medication as prescribed, assess general status, and response to therapy. Visit frequency based on prescribed dosage orders. ❒ Pharmacy to dispense ancillary supplies as needed to establish IV & administer drug.

Prescription Information

NOTE: OH law allows 1 prescription per preprinted order form. Please use additional forms for more than 1 prescription.

Medication	Dose	Directions	Quantity	Refills
❒ Aldurazyme®	❒ 2.9 mg vial	Dose:________________ mg units IV Volume to infuse:______________________ Frequency: ___________________________ Rate (ml): ___________________________ ❒ Titrate per manufacturer guidelines	❒ 28 Day Supply	❒ ______
❒ Cerezyme®	❒ 400 unit vial			
❒ Elaprase®	❒ 6 mg vial			
❒ Fabrazyme®	❒ 5 mg vial ❒ 35 mg vial			
❒ Lumizyme®	❒ 50 mg vial			
❒ Nexviazym Home Infusion Ineligible	❒ 100 mg vial			
❒ VPRIV®	❒ 200 unit vial ❒ 400 unit vial			
❒ Cerdelga	❒ 84mg Capsule	Take 1 capsule _____ times (s) per day.	❒ 28 Day Supply	❒ ______
❒ Sterile Water	❒ 10 ml	UAD for reconstitution of Enzyme	❒ 28 Day Supply	❒ ______
❒ Sodium Chloride 0.9%	❒ 100ml ❒ 200ml ❒ 500ml	Use to further dilute reconstituted Enzyme	❒ 28 Day Supply	❒ ______
❒ Dextrose 5%	❒ 100ml ❒ 200ml ❒ 500ml	Use to further dilute reconstituted Nexviazyme	❒ 28 Day Supply	❒ ______
❒ Normal saline flush	❒ 10 ml PFS	Flush line with 5-10 mls before & after IV drug & PRN line care	❒ 28 Day Supply	❒ ______
❒ Heparin 100 units flush	❒ 5 ml PFS	Flush line with 3-5 mls post infusion & PRN line care	❒ 28 Day Supply	❒ ______
❒ Lidocaine/Prilocaine Cream 2.5%-2.5%	❒ 30gm	Apply topically to needle insertion site 30-60 minutes prior to needle insertion as directed	❒ 28 Day Supply	❒ ______
❒ Pre-Treatment:	❒ Acetaminophen 325mg PO	Take 1-2 Tablets PO 30-60 minutes prior to infusion and every 4-6 hours PRN. Maximum 4 doses per day.	❒ 10 Tablets	❒_______
	❒ Diphenhydramine 25mg Capsules	Take 1-2 Capsules PO 30-60 minutes prior to infusion and every 4-6 hours PRN. Maximum 4 doses per day.	❒ 10 Capsules	❒_______
❒ Adverse reaction medications: To be available at all times	❒ EpiPen 0.3 mg Auto-injector ❒ Substitution allowed	UAD IM PRN severe anaphylactic reaction times one dose; may repeat one time. Dispense 0.3 mg for patient weighing greater than or equal to 30 kg.	❒ 2Pk	❒ ______
	❒ Diphenhydramine 25-50mg Capsules	Administered by mouth prn allergic reactions/anaphylaxis	❒ 10 Capsules	❒_______

Prescriber and Shipping Information (Please print)

Prescriber:____ NPI:_________________________________

Ship to: ❒ Patient ❒ Office ❒ Other:____

Office Address:____ City:____________________________ State:_____ Zip Code:__________

Office Phone Number:_________________________ Office Fax Number:_________________________

Signature:____ Date:_______________

We will dispense this prescription as generic, unless the prescriber indicates "Dispense as Written"_______________________

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.