Infusion Associates
Phone: 616-954-0600 Fax: 616-954-1675

Cerezyme (imiglucerase) IV

******Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications*

Date: _____/_____/_____

Patient Name: ____ **DOB**: _____/_____/_____

Allergies: ______________________________ **Patient Weight:** _________lbs / kg **Height:**_________

Diagnosis: _____________**Gaucher disease**____

ICD-10 codes : _______________________, _______________________, _____________________

Is patient enrolled in the Genzyme Gaucher registry? Yes No

LABS to be drawn: ☐ **CBC** ☐ Other: ________________________________

Lab Frequency: ____

Pre- Medications:				
	Acetaminophen PO	650mg	☐Yes	☐ No
	Diphenhydramine PO or IV	25mg or 50mg	☐Yes	☐ No
	Cetirizine PO	10mg	☐Yes	☐ No

Medication order:

Cerezyme (*imiglucerase*) IV Dosage:
60 units/kg
Other: ___________

Frequency: Every OTHER week

Printed Provider's Name: ____

Provider Signature: ____

Office Phone Number: _______________________**Office Fax Number:**_________________________________