Email: intake@infuseone.com | Phone: 1-800-581-0645 |
Please refer to website www.infuseone.com for location specific fax numbers

INFUSE ONE

VPRIV (velaglucerase alfa) Infusion Orders

Patient Name: DOB: ☐ Male ☐ Female

Diagnosis (please provide ICD10 code)

Other:

☐ NKDA Allergies:

☐ New Start Therapy ☐ Continuation of Therapy Date of last dose (if applicable):

Ordering Provider:

Provider NPI: Phone: Fax:

Practice Address: City: State: Zip Code:

PRE-MEDICATION

☐ Acetaminophen1000mg
☐ PO Diphenhydramine 25mg
☐ PO Ceterizine 10mg PO
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP

REQUIRED DOCUMENTS:

☑ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (please attach)

VPRIV orders:

☑ Patient Weight: _____ kg/ OR _____ lbs

☐ Dose: 60 units/kg IV administered every two weeks as a 60 minute infusion

☐ Other: _____ units IV every two weeks as a 60 minute infusion

☐ Additional Orders/Comments: _____

☐ **REFILLS:** _____

(if not indicated prescription will expire one year from date signed)

Infuse One Standing Orders:

☑ Provide treatment under Infuse One's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

_____

Provider Name

_____ _____

Provider Signature Date

Consider slowing infusion rate, treatment with antihistamines, antipyretics and/or corticosteroids, and/or stopping treatment if a hypersensitivity reaction occurs during an infusion. Consider pre-treatment with antihistamines and/or corticosteroids in patients with prior reactions.