KAISER PERMANENTE®

Kaiser Permanente Washington Home Infusion Pharmacy (KPWAHIP) Elaprase (Idursulfase) Prescription Referral Form

	Phone: (206) 326-2990 Fax Referral To: (206) 326-213
1 PATIENT INFORMATION	2 PRESCRIBER INFORMATION
Patient Name:	
Phone:	Prescriber's Name:
Address:	DEA#:NPI:
City:State:Zip:	Clinic/Facility Name:
MRN #:	Address:
DOB:	City:State:ZIP:
Drug Allergies:	Phone:Fax:
3 Instructions to Provider	
All orders with ✓ will be placed unless otherwise noted. Please fax completed order form to 206-326-2139. For drug prior authorization, call 1-888-767-4670 or visit <u>https://wa-provider.kaiserpermanente.org/provider-manual/clinical-review/preservice</u> .	
4 CLINICAL INFORMATION	
	Data of Last Daca
Diagnosis (ICD-10 code):	Date of Last Dose:
5 ELEPRASE PRESCRIPTION INFORMATION	
Elaprase (Idursulfase)	Route: Intravenous
First Dose: No Yes	Weight:kg Date Recorded:
Dose: □ 0.5 mg/kg x weight=mg □ Other	
Frequency: Once weekly 🛛 Other	
Refills: 🗆 11 months 🛛 Other	
Infusion Access: PIV CVAD Other:	
Infusion Rates, and Supplies: Per protocol (See below) Special Instructions (Specify below)	
Patient's Current Home Care/Specialty Pharmacy:	
Infusion Reaction Medications & Supplies	
 Hydrocortisone sodium succinate injectable 100 mg IV 	 Diphenhydramine injectable 25 mg IV
Sig: Once PRN for hypersensitivity	Sig: Once PRN, may repeat x1 for urticaria, pruritis,
✓ Epinephrine Auto-Injector □ 0.15mg □ 0.3mg QTY: 2	shortness of breath
Sig: Inject into lateral thigh muscle for severe allergic 🗸 Sodium Chloride 0.9% IV 250ml Bag	
reaction. Seek medical attention after use. Sig: Once PRN for anaphylaxis	
 Sodium Chloride 0.9% IV Flush: Flush 10 ml IV before/after medication administration or as needed for line maintenance 	
• Source Chorae C.5% IV Fight. Fight to the two before/after medication administration of as needed for the maintenance	
Labs /Special Instructions/Pre-Meds:	
Infusion Protocol:	Observe patient for signs of infusion rate-related adverse
Infuse per manufacturer guidelines	reactions:
• Monitor vital signs (Temp, BP, HR, RR) every 15 minutes x 4;	 Blood pressure changes, increased pulse rate
then every 30 minutes x2; then every 60 minutes until	• Fever, chills
completion of infusion	• Headache
Documentation must include:	 Chest, back or hip pain
 Start and end time of infusion 	 Dyspnea
	 Mild erythema
 All rate changes, vital signs, including initial and final set Batient response 	
Patient response	
6 PHYSICIAN SIGNATURE REQUIRED	
X	X
SUBSTITUTION PERMITTED (Date)	DISPENSE AS WRITTEN (Date)
CONFIDENTIALITY NOTICE: This message and any attached files might contain confidential info	rmation protected by federal and state law. The information is intended only for the use of the

CONFIDENTIALITY NOTICE: This message and any attached files might contain confidential information protected by federal and state law. The information is intended only for the use of the individual(s) or entities originally named as addressees. The improper disclosure of such information may be subject to civil or criminal penalties. If this message reached you in error, please contact the sender and destroy this message. Disclosing, copying, forwarding, or distributing the information by unauthorized individuals or entities is strictly prohibited by law. **Members with Medicare Part B or D coverage are not required to use this form.**