

1 PATIENT INFORMATION Patient Name: _____ Phone: _____ Address: _____ City: _____ State: _____ Zip: _____ MRN #: _____ DOB: _____ Drug Allergies: _____	2 PRESCRIBER INFORMATION Prescriber's Name: _____ DEA#: _____ NPI: _____ Clinic/Facility Name: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____
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3 Instructions to Provider

All orders with ✓ will be placed unless otherwise noted. Please fax completed order form to 844-785-3104. For drug prior authorization, call 1-888-767-4670 or visit <https://wa-provider.kaiserpermanente.org/provider-manual/clinical-review/preservice>.

4 CLINICAL INFORMATION

Diagnosis (ICD-10 code): _____ Date of Last Dose: _____

5 VPRIV PRESCRIPTION INFORMATION

Velaglucerase alfa (VPRIV) IV infusion in 100 mL 0.9% Normal Saline Route: Intravenous

First Dose: No Yes **Weight:** _____ kg **Date Recorded:** _____

Dose: _____ **Units = 60 units/kg x weight (kg)**

Refills: 11 months Other _____

Frequency: Every 2 weeks

Infusion Access: PIV CVAD Other: _____

Patient's Current Home Care/Specialty Pharmacy: _____

Infusion Reaction Medications & Supplies

<ul style="list-style-type: none"> ✓ Hydrocortisone sodium succinate injectable 100 mg IV Sig: Once PRN for hypersensitivity ✓ Epinephrine Auto-Injector <input type="checkbox"/> 0.15mg <input type="checkbox"/> 0.3mg QTY: 2 Sig: Inject into lateral thigh muscle for severe allergic reaction. Seek medical attention after use. ✓ Sodium Chloride 0.9% IV Flush: Flush 10 ml IV before/after medication administration or as needed for line maintenance 	<ul style="list-style-type: none"> ✓ Diphenhydramine injectable 25 mg IV Sig: Once PRN, may repeat x1 for urticaria, pruritis, shortness of breath ✓ Sodium Chloride 0.9% IV 250 ml Bag Sig: Once PRN for anaphylaxis
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Labs /Special Instructions/Pre-Meds: _____

<p>Infusion Protocol:</p> <ul style="list-style-type: none"> • Infuse per manufacturer guidelines • Monitor vital signs (Temp, BP, HR, RR) every 15 minutes x 4; then every 30 minutes x2; then every 60 minutes until completion of infusion • Documentation must include: <ul style="list-style-type: none"> ○ Start and end time of infusion ○ All rate changes, vital signs, including initial and final set ○ Patient response 	<ul style="list-style-type: none"> • Observe patient for signs of infusion rate-related adverse reactions: <ul style="list-style-type: none"> ○ Blood pressure changes, increased pulse rate ○ Fever, chills ○ Headache ○ Chest, back or hip pain ○ Dyspnea ○ Mild erythema
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6 PHYSICIAN SIGNATURE REQUIRED

X _____ SUBSTITUTION PERMITTED (Date)	X _____ DISPENSE AS WRITTEN (Date)
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