

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: _____
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 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 <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> Velaglycerase alfa (VPRIV) IV infusion in 100 mL 0.9% Normal Saline First Dose: <input type="checkbox"/> No <input type="checkbox"/> Yes Dose: _____ Units = 60 units/kg x weight (kg) Refills: <input type="checkbox"/> 11 months <input type="checkbox"/> Other _____ Frequency: Every 2 weeks Infusion Access: <input type="checkbox"/> PIV <input type="checkbox"/> CVAD <input type="checkbox"/> Other: _____ Patient's Current Home Care/Specialty Pharmacy: _____ </div> <div style="width: 45%;"> Route: Intravenous Weight: _____ kg Date Recorded: _____ </div> </div> Infusion Reaction Medications & Supplies <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> ✓ 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 </div> <div style="width: 45%;"> ✓ 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 </div> </div> Labs /Special Instructions/Pre-Meds: _____ _____ _____	
Infusion Protocol: <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
6 PHYSICIAN SIGNATURE REQUIRED	
X _____ SUBSTITUTION PERMITTED (Date)	X _____ DISPENSE AS WRITTEN (Date)

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