HERITAGE SPECIALTY PHARMACY

VPRIV® (velaglucerase alfa) Patient Referral Form

Admissions Fax # 844-878-6917

Admissions Phone # 855-WE-R-RARE (855-937-7273)

Patient Demographics Information

Patient Name	SSN#	DOB

Patient Address

Primary Phone	Cellular Phone	Work Phone

Emergency Contact Name, Relationship	Emergency Contact Phone Number

Additional Documentation Needed

- Copy of insurance cards
- Patient face sheet w/demographics
- History and Physical

Patient Insurance Information

Insurance Plan #1		Insurance Plan #2	
Subscriber Name	DOB	Subscriber Name	DOB
Policy Number	Group ID	Policy Number	Group ID

Patient Clinical Information

Gender ☐ M ☐ F	Height (inches)	Weight (lbs)	Allergies (food/drug)

Statement of Medical Necessity / Primary Diagnosis

ICD10 Description of diagnosis

Medication Information / Prescription and Orders

Medication	Dosing	Quantity / Refills
VPRIV® (velaglucerase alfa)	_____ units (60 units/kg) IV every other week Infuse over 60 minutes per manufacturer guidelines Titrate rate per pharmacy rate table provided Administering RN to monitor patient for at least 15 minutes post infusion	Dispense: 1 month supply, refill x12mos unless otherwise noted ☐ Other

Line Access

Line Type: ☐ PIV ☐ Port/CVAD

RN to start peripheral IV or use existing CVAD. RN to administer catheter flushing and medications per orders below.

☐ Sodium Chloride 0.9% 10 mL Flush: Flush with 2-10 mL sodium chloride 0.9% IV before medication administration or every 24 hours while IV access in place.

☐ Sodium Chloride 0.9% 10 mL STERILE Flush: Flush with 5-10 mL STERILE sodium chloride 0.9% IV as needed for port access.

☐ Heparin Lock 100 units/mL 5 mL Flush: Lock with 5 mL heparin 100 units/mL after each use or daily while port accessed.

Quantity / Refills

Quantity #QS + PRN refills
unless otherwise noted
☐ Other

Premedications

☐ Give premedication(s) 30 minutes prior to infusion. *(If liquid selected, entire bottle will be dispensed)*

Antipyretic:
- Acetaminophen 325mg tab: ☐ 325-650 mg PO **OR** 160mg/5mL liquid: ☐ _____ mg (10-15mg/kg/dose) PO

Antihistamine (non-sedating):
- Cetirizine 10mg tab: ☐ 10 mg PO **OR** 100mg/mL liquid: ☐ _____ mg (2.5-5mg) PO
- Fexofenadine 180mg tab: ☐ 180 mg PO **OR** 30mg/5mL liquid: ☐ _____ mg (15-60mg) PO
- Loratadine 10mg tab: ☐ 10 mg PO **OR** 5mg/5mL liquid: ☐ _____ mg (5-10mg) PO

Corticosteroid:
- methylPREDNISolone 4mg/mL vial: ☐ _____ mg IV
- predniSONE 20mg tab: ☐ _____ mg PO

Notes to Infusion RN

- Administering RN to observe patient for at least 15 minutes after the infusion to assess for development of anaphylaxis.
- An in-date EPINEPHrine dose must be in the home prior to initiation of infusion.

Adverse Reaction Orders

In the event of an infusion reaction (ie: fever, chills, backache, headache, rigors) the following orders will be followed and prescriber will be notified.
- Mild reaction: Give diphenhydrAMINE 50 mg PO x1 dose and slow infusion. If needed, give an additional dose of diphenhydrAMINE 50 mg PO x1 dose (Max 2 doses).
- Moderate reaction: Give diphenhydrAMINE 50 mg po x1 dose and stop infusion; Sodium Chloride 0.9% 250mL IV wide open as needed.
- Severe reaction (w/breathing problems): Stop infusion, give diphenhydrAMINE 50mg IM x1 dose and EPINEPHrine IM 0.3mg or 0.15mg, (per pt wt), and call 911.

Prescriber Information

Prescriber Name	Office Contact

Practice Address	Practice Phone

NPI#	License #	Practice Fax

Prescriber Signature Required - Substitution Permitted	Date	Prescriber Signature Required - Dispense as Written	Date