Infusion ASSOCIATES

Phone: 833-394-0600 Fax: 833-996-4888

VPRIV Infusion

*Please fax a copy of patient's Demographics, Insurance Information, H&P, Diagnostic lab report (**genetic testing results**), Current Medications and Recent Visit Notes*

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

ICD-10 : _____, _____, _____

*****Attach genetic testing results*****

Is patient enrolled in the Genzyme Gaucher registry? ☐Yes ☐ No

Labs to be collected: ☐CMP ☐CBC w/o diff ☐CBC w/diff ☐CBC w/man diff ☐ Other:_____

Lab Frequency: ☐ EVERY 3 months ☐ EVERY 6 months ☐ Other:_____

Pre-Medications:	**Diphenhydramine PO or IV**	25mg or 50mg	☐Yes ☐ No
	Cetirizine PO	10mg	☐Yes ☐ No
	Acetaminophen PO	650mg	☐Yes ☐ No

VPRIV (velaglucerase alfa) IV

Dose: 60 units/kg

Frequency: q2 weeks

Printed Provider Name: _____

Provider Signature: _____

Office Phone Number: _____**Office Fax Number:**_____

New referring providers, how did you hear about us? ☐Web Search ☐Pharma Rep ☐ Drug Locator ☐Patient ☐Word of Mouth ☐IA Clinical Liaison ☐IA Website ☐Facebook ☐Instagram ☐ Other: _____