

# Idursulfase (Elaprase)

Provider Order Form rev. 2/28/2023



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## PATIENT INFORMATION

Referral Status:  New Referral  Updated Order  Order Renewal

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

ICD-10 code (required): \_\_\_\_\_ ICD-10 description: \_\_\_\_\_

NKDA Allergies: \_\_\_\_\_ Weight (lbs/kg): \_\_\_\_\_ Height: \_\_\_\_\_

Patient Status:  New to Therapy  Continuing Therapy Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

## PROVIDER INFORMATION

Referral Coordinator Name: \_\_\_\_\_ Referral Coordinator Email: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## NURSING

- Provide nursing care per 360 Infusion Center Nursing Procedures, including reaction management and post-procedure observation

## LABORATORY ORDERS

- CBC  at each dose  every \_\_\_\_\_
- CMP  at each dose  every \_\_\_\_\_
- CRP  at each dose  every \_\_\_\_\_
- Other: \_\_\_\_\_

## PRE-MEDICATION ORDERS

- acetaminophen (Tylenol)  500mg /  650mg /  1000mg PO
- cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- diphenhydramine (Benadryl)  25mg /  50mg  PO /  IV
- methylprednisolone (Solu-Medrol)  40mg /  125mg IV
- hydrocortisone (Solu-Cortef)  100mg IV
- Other: \_\_\_\_\_
- Dose: \_\_\_\_\_ Route: \_\_\_\_\_
- Frequency: \_\_\_\_\_

## THERAPY ADMINISTRATION

- Idursulfase** (Elaprase) in 100ml 0.9% sodium chloride, intravenous infusion
  - Dose: 0.5mg/kg
  - Route:  intravenous
  - Frequency: once every week
  - The total volume of infusion should be administered over a period of 3 hours, which may be gradually reduced to 1 hour if no hypersensitivity reactions are observed.
- Infuse with a low-protein-binding 0.2 micrometer (Ø<sup>m</sup>) in-line filter.
- Flush with 0.9% sodium chloride at infusion completion
- Patient is required to stay for 30-minute observation period
- Refills:  Zero /  for 12 months /  \_\_\_\_\_ (if not indicated order will expire one year from date signed)

## SPECIAL INSTRUCTIONS

Provider Name (Print)

Provider Signature

Date