

# TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: intake@12stonehealth.com



## CEREZYME ORDER FORM

Date: _____	ICD-10 Code: _____	<b>Therapy Status</b> <input type="checkbox"/> New Start <input type="checkbox"/> Continuing Therapy: Last Dose: _____
Patient Name: _____	Allergies: _____	
Date of Birth: _____	Weight: _____ lbs OR _____ kg	

### Provider Information

Ordering Provider: _____	Provider Fax: _____
Provider NPI: _____	Provider Address: _____
Provider Phone: _____	

### MEDICATION ORDER

<b>Cerezyme</b>	<input type="checkbox"/> Administer Cerezyme _____ U/kg IV every _____ weeks per protocol.	Refills for one year from date of signature unless indicated below.  _____ Refills
	<input type="checkbox"/> Administer Cerezyme _____ U/kg IV _____ times per week per protocol.	

### PRE-MEDICATIONS

<b>Oral</b> <input type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg _____ 650mg <input type="checkbox"/> Loratadine: 10mg <input type="checkbox"/> Cetirizine: 10mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____	<b>IV</b> <input type="checkbox"/> Dexamethasone: _____ 4mg _____ 8mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Methylprednisolone: 125mg <input type="checkbox"/> Hydrocortisone: 100mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____
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### LAB ORDERS (please indicate any labs to be drawn and frequency)

### OTHER REQUIRED DOCUMENTATION

**Surveillance lab ordering and monitoring is the responsibility of the prescriber**	(Please fax this signed order form, along with the following documents to 800-223-4063) <ul style="list-style-type: none"><li>• History &amp; Physical, Last Office Visit Note</li><li>• Patient Demographics and Insurance Information</li><li>• Medication List</li><li>• Recent Lab Work</li></ul>
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By signing below, I certify that the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written:  _____ Prescriber Name	Substitution Allowed:  _____ Prescriber Name
_____ Date	_____ Date