

**ELAPRASE (IDURSULFASE)
INFUSION ORDERS**

****REQUIRED INFORMATION****

- ☐ This signed order form from the provider
☐ Patient demographics & insurance information
☐ **Clinical/Progress Notes** supporting primary diagnosis

Patient Name:	DOB:
Allergies:	Patient Phone:

Diagnosis:

- ☐ Hunter Syndrome (ICD-10: _____)

J Code: J1743

ELAPRASE ORDERS

☐ 0.5 mg/kg IV every week

Pt. Weight _____ kg

Premedications: ☐ Tylenol 1000 mg PO ☐ Benadryl 25 mg PO to be given 30 minutes before infusion (if not contraindicated).

****Patient must bring own EpiPen to each infusion.**

****Once we receive all necessary documentation, we will schedule the patient's treatment.**

Additional Instructions:

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Physician Name:	Phone:	Fax:
**Physician Signature:	Date:	