vitalcare INFUSION SERVICES of SIOUX FALLS

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VPRIV
(VELAGLUCERASE ALFA FOR INJECTION)
INFUSION ORDERS

****REQUIRED INFORMATION****

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

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis: Gaucher Disease (ICD-10: _____)

VPRIV ORDERS

Patient Weight:_____kg

☐ Initial Dose: 60U/kg IV administered every two weeks as a 60 minute infusion
☐ Other: _____U IV every two weeks as a 60 minute infusion

Pre-Medications *(optional)*:

☐ Acetaminophen _____ mg PO before infusion
☐ Diphenhydramine _____mg PO/IV before infusion
☐ Solu-medrol _____mg IV before infusion

Additional Instructions:

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