vitalcare
of CENTRAL MISSISSIPPI

Fountains Infusion Center

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Phone: 601.859.8200 Fax: 601.859.8201

VPRIV (VELAGLUCERASE ALFA) 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:**	