

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:	