Elaprase (idursulfase)

Provider Order Form *rev. 1/2/2025*

AMERICAN INFUSION CARE
SPECIALTY INFUSION

PATIENT INFORMATION

Referral Status: ☑ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

☐ E76.1 Mucopolysaccharidosis, type II (Primary diagnosis)

☐ E76.3 Mucopolysaccharidoses, unspecified (Secondary or alternate if specific type not documented

☐ Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.
Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications 30 minutes prior to infusion

☐ Acetaminophen (Tylenol) ☐500mg ☐650mg ☐ 1000mgPO
☐ Diphenhydramine (Benadryl) ☐25mg ☐50mg ☐ PO ☐ IV
☐ Other: _____ Dose: _____ Route: _____

Lab Orders

Required: Idurnonate-2 sulfatase (I2S), Genetic Testing (IDS gene)
☐ Other: _____

patient must bring own Epi Pen to each infusion

Idursulfase (Elaprase) (Select one):

Administer in 100ml 0.9% sodium chloride, intravenous infusion.
-The total volume of infusion should be administered over a period of 3 hours, which may be gradually reduced to 1 hour if no hypersensitivity reactions are observed
-Infuse with a low-protein-binding 0.2 micrometer (10^-3 m) in-line filter

☐ Infuse 0.5 mg/kg IV weekly
☐ Other: _____

Post Treatment Observations: Flush with 0.9% sodium chloride at infusion completion. The patient is required to stay for 30 minutes following the first administration.

Special Instructions: _____

☐ **Refills:** ☐ zero ☐6 months ☐12 months ☐ _____ *(Prescription valid for one year, unless otherwise indicated)*

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

Provider Name (Print) *Provider Signature* *Date*

E: Referrals@americaninfusioncare.com
Americaninfusioncare.com

Greater Houston Area F: 832.510.7824 P: 832.800.3213
McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454
Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213
Other Locations (Oaklawn, Lancaster, etc): F: 469.305.2361 P: 972.865.4454