Cox	Heal	th a	at ł	Home

VPRIV[®]

CoxHealth	(velagluc	erase alfa)	Fax: 1-417-269-0692
Patient Information		Prescriber	
Name:	_DOB:	Prescriber name:	
Height: 🖬 in 🖬 cm Weig	ht 🖬 kg 🖬 lbs	NPI:	
Address:			
City:State:			State:Zip:
Phone:Alternate:		Contact:	
SSN:		Phone:	Fax:
PLEASE INCLUDE ON FAX A AND BACK OF INSURAN Clinical Information (Please	NCE CARD(S)	linical and lab	information)
Clinical mornation (Please	-	22 (Gaucher disease)	mormation
□ Other:			
Allergies:			
Intravenous VPRIV [®]			
Flushing/Premedication Orders:			
✓ Flushing per CoxHealth at Home pre	otocol		
✓ PIV: 0.9% sodium chloride	3-20mL before and after	infusion as needed	
 ✓ Port: 0.9% sodium chloride fore and after infusion as r 			: monthly, 0.9% sodium chloride 3-20mL be- er infusion
✓ No routine premedication necessar	y. If desired, please write	here:	
VPRIV [®] (velaglucerase alfa) IV over at I	east 1 hour		
Frequency:			
✓ Every 2 weeks			
Dose: Rph will round up to the nearest	vial size.		
🗅 60 units/kg 🖵 Other	Dilute in 100ml 0.9% sodi	um chloride	
Quantity to dispense: 2 1 dose with 24	refills (1 year) or 🖵	infusion(s)	
Labs: every (frequency) 🖵 CBC	C with diff 🗖 CMP 🗖 aPT	□Other:	
Prescriber's Signature:			Date
I authorize CoxHealth at Home and its representatives to act as an agent stand that I can revoke this designation at any time by providing written n		thorization process for this prescriptior	and any future fills of the same prescription for the patient listed above. I under-

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