Enzyme Replacement Referral Form

MedPro Rx™
A DIPLOMAT® COMPANY

Phone: (888) 571-3100 • Fax: (800) 582-9315

Demographics

Patient Name: ______________________

Address: ______________________

City: __________ State: ________ Zip: __________

Date of Birth: __________ Sex: ☐ Male ☐ Female

Phone: (*home*) ______________________

(*work*) ______________________

(*cell*) ______________________

Social Security Number: ______________________

Next of Kin: ______________________

Height: __________ Weight: __________

Insurance Information:

Primary Insurance: ______________________

Member ID #: __________ Group #: __________

Policy Holder: __________ Relationship: __________

Secondary Insurance: ______________________

Member ID #: __________ Group #: __________

Policy Holder: __________ Relationship: __________

Diagnosis: *(Please check one of the following)*

☐ 272.7 Fabry Disease

☐ 272.7 Gaucher Disease

☐ Other: ______________________

ICD-9 Code: ______________________

Allergies: ______________________

Date of last dose: ______________________

Date: ______________________

Physician Orders: *(Please check the following)*

☐ Fabrazyme

☐ Cerezyme

☐ Other ______________________

Dose ______________________

Frequency ______________________

☐ Benadryl 25 – 50 mg PO ______________________

☐ Benadryl 25 – 50 mg IV ______________________

☐ Tylenol 650 or 1000 mg PO ______________________

☐ Skilled Nursing visits as required

☐ Standard supplies as requested

☐ 0.9% sodium chloride flush 5-10ml pre/post infusion and PRN

☐ Heparin 10units/ml 5ml post infusion and PRN

☐ Heparin 100units/ml 5ml post infusion and PRN

Prescribing Physician:

Name: ______________________

Address *(please include facility name)*:

____

____

____

Phone: __________ Fax: __________

Specialty: ______________________

License #: __________ UPIN #: __________

DEA #: __________ NPI #: __________

I have read this entire form and verify to its accuracy ☐ Yes

Prescriber Signature: ______________________
Dispense as written

Prescriber Signature: ______________________
Substitution allowed

Date: ______________________

MedPro Rx, Inc. is compliant with HIPAA Guidelines

Please to email this form automatically, or attach manually to: referrals@medprorx.com

Or Fax Completed Copies of the Following to MedPro Rx @ 1-800-582-9315: (1) Referral Form and (2) Your Insurance Card(s)

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