BLUEGRASS PHARMACY | LYSOSOMAL STORAGE DISORDERS ENROLLMENT FORM

BLUEGRASS Pharmacy
A Member of the Wellpartner Family

FAX FORM TO: 1.866.233.8317 | **PHONE:** 1.855.492.0817 | **EMAIL:** contact@bluegrass-rx.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION

Name:
Address:
City, State, ZIP:
Primary Phone: - - DOB: / /
Alternate Phone: - - Gender:
Email:
Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:
DEA #: NPI #: State Lic. #:
Group or Hospital:
Address:
City, State, Zip:
Phone: - - Fax: - -
Contact Person: Phone: - -

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Primary Insurance Company Name:
Primary Cardholder Name:
Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent
Phone: - - Member ID: Group #:

Secondary Insurance Company Name:
Secondary Cardholder Name:
Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent
Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / /
Ship to: ◯ Patient ◯ Office ◯ Other:
Date of Diagnosis: / /
Gauchers Disease: ◯ Type 1 ◯ Type 2 ◯ Type 3

◯ E74.Ø2 Pompe Disease
◯ E75.21 Fabry Disease
◯ E75.22 Gaucher Disease
◯ E76.Ø1 Hurler's Syndrome
◯ E76.Ø3 Scheie's Syndrome
◯ E76.219 Mucopolysaccharidosis, Type II
◯ Other:

Does the patient have clinical symptoms of Fabry disease? ◯ Yes ◯ No
Pompe Disease: ◯ Infantile Onset ◯ Late Onset Port: ◯ Yes ◯ No
Site of care: ◯ MD Office ◯ Infusion Clinic ◯ Hospital Outpatient ◯ Home Health ◯ Other:
Nursing needed? ◯ Yes ◯ No Agency of Choice:
Allergies:
Height (in/cm): Weight (lb/kg): Current Medications:

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
◯ Aldurazyme	2.9 mg vial	Dose: _____ mg _____ mg/kg body weight, IV ◯ Ramping Required Volume to infuse: _____ ml Rate: _____ ml Frequency: _____		◯ 12 months ◯
◯ Cerezyme	400 unit vial	Dose: _____ mg _____ mg/kg body weight, IV ◯ Ramping Required Volume to infuse: _____ ml Rate: _____ ml Frequency: _____		◯ 12 months ◯
◯ Elaprase	6 mg vial	Dose: _____ mg _____ mg/kg body weight, IV ◯ Ramping Required Volume to infuse: _____ ml Rate: _____ ml Frequency: _____		◯ 12 months ◯
◯ Fabrazyme	◯ 5 mg vial ◯ 35 mg vial	Dose: _____ mg _____ mg/kg body weight, IV ◯ Ramping Required Volume to infuse: _____ ml Rate: _____ ml Frequency: _____		◯ 12 months ◯
◯ Lumizyme‡ (LD)*	(LD)* This is a limited distribution drug that requires additional handling. Please call (1.855.492.0817) for more information.			
◯ Myozyme	50 mg vial	Dose: _____ mg _____ mg/kg body weight, IV ◯ Ramping Required Volume to infuse: _____ ml Rate: _____ ml Frequency: _____		◯ 12 months ◯
◯ Naglayme (LD)*	(LD)* This is a limited distribution drug that requires additional handling. Please call (1.855.492.0817) for more information.			
◯ VPRIV	◯ 200 unit vial ◯ 400 unit vial	Dose: _____ mg _____ mg/kg body weight, IV ◯ Ramping Required Volume to infuse: _____ ml Rate: _____ ml Frequency: _____		◯ 12 months ◯
◯ Cerdelga	84 mg capsule	Take 1 capsule _____ times per day		

‡Physicians and patients must register through the Lumizyme ACE program by calling 1.800.745.4447 or at www.lumizyme.com.
Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X / /
DISPENSE AS WRITTEN DATE

X / /
PRODUCT SUBSTITUTION PERMITTED DATE