

**ELAPRASE (IDURSULFASE)
INFUSION ORDERS**

****REQUIRED INFORMATION****

- This signed order form from the provider
- Patient demographics & insurance information
- Clinical/Progress Notes** supporting primary diagnosis

Patient Name:	DOB:
Allergies:	Patient Phone:

Diagnosis:

- Hunter Syndrome (ICD-10: _____)

J Code: J1743

ELAPRASE ORDERS

0.5 mg/kg IV every week

Pt. Weight _____ kg

Premedications: Tylenol 1000 mg PO Benadryl 25 mg PO to be given 30 minutes before infusion (if not contraindicated).

****Patient must bring own EpiPen to each infusion.**

****Once we receive all necessary documentation, we will schedule the patient's treatment.**

Additional Instructions:

Physician Name:	Phone:	Fax:
**Physician Signature:	Date:	