Lumizyme (Alglucosidase alfa)

Provider Order Form rev. 4/10/2022

PATIENT INFORMATION

Referral Status *(check one):* ☐ New Referral   ☐ Updated Order   ☐ Order Renewal

Patient Name: _____   DOB: _____

NKDA ☐   Allergies: _____   Weight _____   *Please specify:* ☐ lbs ☐ kg   Height: _____

Patient Status *(check one):* ☐ New to Therapy   ☐ Continuing Therapy | Last Treatment Date: _____   Next Due Date: _____

ICD-10 code (required): _____   ICD-10 description: _____

> **REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

PRESCRIPTION

NURSING

☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation

LABORATORY ORDERS

☐ CBC   ☐ at each dose   ☐ every _____
☐ CMP   ☐ at each dose   ☐ every _____
☐ CRP   ☐ at each dose   ☐ every _____
☐ Other: _____

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg | ☐ 650mg | ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg | ☐ 50mg | ☐ PO | ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg | ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____   Route: _____
Frequency: _____

THERAPY ADMINISTRATION

☐ **Alglucosidase alfa** (Lumizyme) in 0.9% sodium chloride, intravenous infusion, final concentration of 0.5 to 4mg/ml, administer with 0.2 micron filter
- Dose: ☐ 20mg/kg / ☐ other _____
- Frequency: ☐ every 2 weeks
- Administer over approximately 4 hours, in a step wise manner. Initial infusion rate should be no more than 1mg/kg/hr. Infusion rate may be increased by 2mg/kg/hr every 30 minutes after patient tolerance is established. Max rate is 7mg/kg/hr. If the patient is stable, alglucosidase alfa may be administered at the maximum rate of 7mg/kg/hr until the infusion is completed

☐ Flush with 0.9% sodium chloride at infusion completion

☐ Patient is required to stay for 30-minute observation
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
   (if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: _____   Referral Coordinator Email: _____

Ordering Provider: _____   Provider NPI: _____

Referring Practice Name: _____   Phone: _____   Fax: _____

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

_____   _____   _____
Provider Name [Print]   *Provider Signature*   *Date*

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK