

Alglucosidase alfa (Lumizyme)



Provider Order Form rev. 9/28/2021

PATIENT INFORMATION

| | | |
|--|--------------------------------|------|
| Date: | Patient Name: | DOB: |
| ICD-10 code (required): | ICD-10 description: | |
| <input type="checkbox"/> NKDA Allergies: | Weight lbs/kg: | |
| Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy | Next Due Date (if applicable): | |

PROVIDER INFORMATION

| | | | |
|----------------------------|-----------------------------|--------|-----------|
| Referral Coordinator Name: | Referral Coordinator Email: | | |
| Ordering Provider: | Provider NPI: | | |
| Referring Practice Name: | Phone: | Fax: | |
| Practice Address: | City: | State: | Zip Code: |

NURSING

- Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 09.07.2021)

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
- 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 the completion of infusion
- Patient is required to stay for 30-minute observation period
- Patient is NOT required to stay for observation time
- Refills: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

| | | |
|-----------------------|--------------------|------|
| Provider Name (Print) | Provider Signature | Date |
|-----------------------|--------------------|------|

Email ivxintake@ivxhealth.com or fax this form, insurance card (both sides), demographics, recent H&P, labs, and supporting clinicals to:

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> BAY AREA: 844-899-0275 | <input type="checkbox"/> COLUMBUS: 844-627-2675 | <input type="checkbox"/> JACKSONVILLE: 904-212-2338 | <input type="checkbox"/> PHILADELPHIA: 844-820-9641 | <input type="checkbox"/> WEST TN: 888-615-1445 |
| <input type="checkbox"/> CINCINNATI: 844-946-0868 | <input type="checkbox"/> HARRISBURG: 844-859-4235 | <input type="checkbox"/> KANSAS CITY: 844-900-1292 | <input type="checkbox"/> TAMPA: 844-946-0849 | <input type="checkbox"/> MIDDLE TN: 888-615-1445 |
| <input type="checkbox"/> CHICAGO: 312-253-7244 | <input type="checkbox"/> INDIANAPOLIS: 844-983-2028 | <input type="checkbox"/> ORLANDO: 844-946-0867 | <input type="checkbox"/> WEST FLORIDA: 844-946-0849 | <input type="checkbox"/> EAST TN: 888-615-1445 |