

Alglucosidase alfa (Lumizyme)



Provider Order Form rev. 10/12/2022

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ DOB: _____

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

NKDA Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

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
- 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 period
- Refills: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

Provider Name (Print) _____ Provider Signature _____ Date _____

FAX NUMBERS

- | | | | | |
|---|---|---|---|---|
| <input type="checkbox"/> BAY AREA: 844-889-0275 | <input type="checkbox"/> CONNECTICUT: 860-955-1532 | <input type="checkbox"/> HARRISBURG: 844-859-4235 | <input type="checkbox"/> PALM BEACH: 561-768-9044 | <input type="checkbox"/> TAMPA: 844-946-0849 |
| <input type="checkbox"/> CHARLOTTE: 336-663-0143 | <input type="checkbox"/> CHICAGO: 312-253-7244 | <input type="checkbox"/> INDIANAPOLIS: 844-983-2028 | <input type="checkbox"/> PHILADELPHIA: 844-820-9641 | <input type="checkbox"/> WEST TN/AR: 888-615-1445 |
| <input type="checkbox"/> CINCINNATI: 844-946-0868 | <input type="checkbox"/> COLUMBUS: 844-627-2675 | <input type="checkbox"/> JACKSONVILLE: 904-212-2338 | <input type="checkbox"/> RALEIGH: 919-287-2551 | <input type="checkbox"/> MIDDLE TN: 888-615-1445 |
| | <input type="checkbox"/> DAYTONA: 386-259-6096 | <input type="checkbox"/> KANSAS CITY: 844-900-1292 | <input type="checkbox"/> SARASOTA: 941-870-6550 | <input type="checkbox"/> EAST TN: 615-425-7427 |
| | <input type="checkbox"/> FT. LAUDERDALE: 754-946-2052 | <input type="checkbox"/> ORLANDO: 844-946-0867 | <input type="checkbox"/> SOUTHWEST FL: 813-283-9144 | |