- ☐ *Borough Park* 1428 36th Street Suite 107 Brooklyn, NY 11218
- ☐ *Crown Heights* 555 Lefferts Avenue Brooklyn, NY 11225
- ☐ *Manhattan* 57W 57Street Suite 601 New York, NY 10019
- ☐ *Manhasset* 333 East Shore Road Suite 201 Manhasset, NY 11030
- ☐ *Rockville Centre* 165 North Village Avenue Suite 133 Rockville Center, NY 11570
- ☐ *Elmsford/ Terrytown* 555 Taxter Road 3rd Floor Elmsford, NY 10523
- ☐ *NYC Central Park West* 115 Central Park West Suite 15 New York, NY 10023
- ☐ *Woodbury* 75 Froehlich Farm Woodbury, NY 11797
- ☐ *Staten Island* 27 New Dorp Lane Staten Island, NY 10306

Office: 212-803-3339 Fax : 646-768-8600

- ☐ *Manhattan* 225 E 70th Street Suite 1E New York, NY 10021
- ☐ *Queens* 64-05 Yellowstone Blvd CF104 Forest Hills, NY 11375
- ☐ *Manhattan* 225 East 70th Street New York, NY 10021
- ☐ *Holbrook/ Ronkonkoma* 233 Union Ave Suite 207 Holbrook, NY 11741
- ☐ *Scarsdale* 495 Central Park Avenue Suite 205 Scarsdale, NY 10583
- ☐ *5 Towns* 141 Washington Avenue Cedarhurst, NY 11559
- ☐ *Long Beach* 917 Beech Street Long Beach, NY 11561
- ☐ *Riverhead* 1228 E Main Street Suite A Riverhead, NY 11901
- ☐ *Bronx* 226 West 238th Street Bronx, NY 10463

Alglucosidase alfa (Lumizyme)

Provider Order Form

Date: ____________________

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

PHYSICIAN INFORMATION

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

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: ______________________

SPECIAL INSTRUCTIONS

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 ☐ other ____________
  - Administer over approximately 4 hours, in a step wise manner. Initial infusion rate should be no more than 1mg/k g/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)

Total dosages _______

Refills ___________

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** ______________________ Date ____________

Provider ______________________ Phone ____________ Fax ____________