Westerville
575 Copeland Mill Road
Suite# 2F
Westerville, Ohio 43081

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

Mission Medical

Lancaster
2405 Columbus Street
Suite# 210
Lancaster, Ohio 43130

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 _____