

Lexington
1792 Alysheba Way
Suite 205
Lexington, KY 40509

Bowling Green
727 U.S. 31 W Bypass
Suite 102
Bowling Green, KY 42101



Alglucosidase alfa-ngpt (Nexviazyme) Provider Order Form

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> 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
<input type="checkbox"/> CBC <input type="checkbox"/> at each dose <input type="checkbox"/> every _____
<input type="checkbox"/> CMP <input type="checkbox"/> at each dose <input type="checkbox"/> every _____
<input type="checkbox"/> CRP <input type="checkbox"/> at each dose <input type="checkbox"/> every _____
<input type="checkbox"/> Other: _____

PRE-MEDICATION ORDERS
<input type="checkbox"/> acetaminophen (Tylenol) <input type="checkbox"/> 500mg / <input type="checkbox"/> 650mg / <input type="checkbox"/> 1000mg PO
<input type="checkbox"/> cetirizine (Zyrtec) 10mg PO
<input type="checkbox"/> loratadine (Claritin) 10mg PO
<input type="checkbox"/> diphenhydramine (Benadryl) <input type="checkbox"/> 25mg / <input type="checkbox"/> 50mg <input type="checkbox"/> PO / <input type="checkbox"/> IV
<input type="checkbox"/> methylprednisolone (Solu-Medrol) <input type="checkbox"/> 40mg / <input type="checkbox"/> 125mg IV
<input type="checkbox"/> Other: _____
Dose: _____ Route: _____
Frequency: _____

SPECIAL INSTRUCTIONS
<div style="border: 1px solid black; height: 80px;"></div>

THERAPY ADMINISTRATION
<input type="checkbox"/> Alglucosidase alfa-ngpt (Nexviazyme) in 5% Dextrose, intravenous infusion, final concentration of 0.5 to 4mg/ml, administer with 0.2 micron filter <ul style="list-style-type: none">▪ Dose: <input type="checkbox"/> (≥ 30kg) 20mg/kg▪ <input type="checkbox"/> (≤ 30kg) 40mg/kg <input type="checkbox"/> other _____▪ Frequency: every 2 weeks <input type="checkbox"/> other _____▪ Administer over approximately 4 hours, <input type="checkbox"/> other _____
<input type="checkbox"/> Flush with 5% Dextrose at the completion of infusion
<input type="checkbox"/> Patient is required to stay for 30-minute observation period
<input type="checkbox"/> Patient is NOT required to stay for observation time
<input type="checkbox"/> Refills: <input type="checkbox"/> Zero / <input type="checkbox"/> for 12 months / <input type="checkbox"/> _____ (if not indicated order will expire one year from date signed)
<input type="checkbox"/> Total dosages _____
<input type="checkbox"/> Refills _____

NOTES/ADDITIONAL COMMENTS:
<div style="border: 1px solid black; height: 60px;"></div>

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____