

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 _____
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NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X Date _____

Provider _____ Phone _____ Fax _____