

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



Alglucosidase alfa (Lumizyme)

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

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/kg 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 _____