

TN  
100 Covey Drive  
Suite 307  
Franklin, TN 37067



# 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**

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-ngpt (Nexviazyme) in 5% Dextrose, intravenous infusion, final concentration of 0.5 to 4mg/ml, administer with 0.2 micron filter

- Dose:  (≥ 30kg) 20mg/kg
- (≤ 30kg) 40mg/kg     other \_\_\_\_\_
- Frequency: every 2 weeks     other \_\_\_\_\_
- Administer over approximately 4 hours,  other \_\_\_\_\_

Flush with 5% Dextrose 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 \_\_\_\_\_