Fairfield
1817 Black Rock Turnpike
Suite 204
Fairfield, CT 06824

Greenwich
469 W Putnam Ave
Ste 205,
Greenwich, CT 06830

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

Mission Medical

LAMZEDE(velmanase alfa-tycv) infusion orders

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:

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Alpha-Mannosidosis (E77.1)
☐ Non-central nervous system manifestations

☐ _____ _____ *(other)*

PRE-MEDICATION

☐ Acetaminophen (Tylenol) _____ mg PO
☐ Diphenhydramine (Benadryl) _____ mg PO / IV
☐ Cetirizine (Zyrtec) _____ mg PO
☐ Solu-Medrol (Methylprednisolone) _____ mg IV
☐ Hydrocortisone _____ mg IV
☐ Other: _____

PATIENT WEIGHT

_____ lbs.

_____ kg

DOSAGE:
☐ 1 mg/kg IV infusion (based on actual body weight)
☐ Other_____

Frequency:
☐ Once weekly (every 7 days)

☐ **Route:** Intravenous (IV) infusion

Total dosages_____/ Refills

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____