

Center City
1528 Walnut Street
Suite 1205
Philadelphia, PA 19102



King Of Prussia
216 Mall Blvd
Suite#1
King Of Prussia, PA, 19046

LAMZEDE (velmanase alfa-tycv) infusion orders 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: _____

<p>DIAGNOSIS <i>Please provide ICD-10 code</i></p> <p><input type="checkbox"/> _____ Alpha-Mannosidosis (E77.1) <input type="checkbox"/> Non-central nervous system manifestations</p> <p><input type="checkbox"/> _____ (other)</p> <p>PRE-MEDICATION</p> <p><input type="checkbox"/> Acetaminophen (Tylenol) _____ mg PO</p> <p><input type="checkbox"/> Diphenhydramine (Benadryl) _____ mg PO / IV</p> <p><input type="checkbox"/> Cetirizine (Zyrtec) _____ mg PO</p> <p><input type="checkbox"/> Solu-Medrol (Methylprednisolone) _____ mg IV</p> <p><input type="checkbox"/> Hydrocortisone _____ mg IV</p> <p><input type="checkbox"/> Other: _____</p>	<p>PATIENT WEIGHT</p> <p>_____ lbs.</p> <p>_____ kg</p> <p>DOSAGE:</p> <p><input type="checkbox"/> 1 mg/kg IV infusion (based on actual body weight)</p> <p><input type="checkbox"/> Other _____</p> <p>Frequency:</p> <p><input type="checkbox"/> Once weekly (every 7 days)</p> <p><input type="checkbox"/> Route: Intravenous (IV) infusion</p> <p>Total dosages _____ / Refills _____</p>
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NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____