

Alglucosidase alfa (Lumizyme)



Provider Order Form rev. 08/17/2023

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date:	Patient Name:	DOB:
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:	Weight (lbs/kg):	Height:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy	Last Treatment Date:	Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

NURSING

- ☒ Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation **NOTE:** IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 05.01.2023)

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
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

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
 - Administer over approximately 4 hours, in a step wise manner. Initial infusion rate should be no more than 1mg/kg/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 infusion completion
- ☐ Patient is required to stay for 30-minute observation period
- ☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

Provider Name (Print)

Provider Signature

Date

FAX NUMBERS

- | | | | | |
|---|---|---|---|---|
| ☐ AUSTIN: 512-772-2824 | ☐ CONNECTICUT: 860-955-1532 | ☐ INDIANAPOLIS: 844-983-2028 | ☐ NORTH CENTRAL FL: 352-756-4191 | ☐ RALEIGH: 919-287-2551 |
| ☐ BAY AREA: 844-889-0275 | ☐ DAYTONA: 386-259-6096 | ☐ JACKSONVILLE: 904-212-2338 | ☐ NORTH JERSEY: 551-227-2823 | ☐ SAN ANTONIO: 726-238-9950 |
| ☐ CHARLOTTE: 336-663-0143 | ☐ DELAWARE: 302-596-8553 | ☐ KANSAS CITY: 844-900-1292 | ☐ NORTHWEST AR: 888-615-1445 | ☐ SARASOTA: 941-870-6550 |
| ☐ CHICAGO: 312-253-7244 | ☐ EAST TN: 615-425-7427 | ☐ LAKELAND: 863-316-3910 | ☐ ORLANDO: 844-946-0867 | ☐ SOUTH JERSEY: 856-519-5309 |
| ☐ CINCINNATI: 844-946-0868 | ☐ FT. LAUDERDALE: 754-946-2052 | ☐ LITTLE ROCK: 501-451-5644 | ☐ PALM BEACH: 561-768-9044 | ☐ SOUTHWEST FL: 813-283-9144 |
| ☐ COLUMBUS: 844-627-2675 | ☐ HARRISBURG: 844-859-4235 | ☐ MIAMI: 786-744-5687 | ☐ PHILADELPHIA: 844-820-9641 | ☐ TAMPA: 844-946-0849 |
| | ☐ HOUSTON: 832-631-9595 | ☐ MIDDLE TN: 888-615-1445 | ☐ PIEDMONT TRIAD: 336-790-2200 | ☐ WEST TN: 888-615-1445 |