

Borough Park
1428 36th Street
Suite 107
Brooklyn, NY 11218

Crown Heights
555 Lefferts Avenue
Brooklyn, NY 11225

Manhattan
57 West 57 Street
Suite 601
New York, NY 10019



Queens
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

Riverhead
1228 E Main Street
Suite A
Riverhead, NY 11901

Manhasset
333 East Shore Road
Suite 201
Manhasset, NY 11030

Rockville Centre
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

Manhattan
225 East 70th Street
New York, NY 10021

Holbrook/Ronkonkoma
233 Union Ave
Suite 207
Holbrook, NY 11741

Scarsdale
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

Elmsford/ Terrytown
555 Taxter Road
3rd Floor
Elmsford, NY 10523



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

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:

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: (\geq 30kg) 20mg/kg
 - (\leq 30kg) 40mg/kg
 - Frequency: every 2 weeks
 - Administer over approximately 4 hours,
- 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)

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____