

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: (≥ 30 kg) 20mg/kg
- (≤ 30 kg) 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 _____