Palmetto Infusion Services
COMPLIANCE

Phone: 800-809-1265

MRN:_____
DOB:_____

Standard Plan of Treatment for Lumizyme

(Re)Certification Period From_____to_____

Note: We may require MD office notes and may require a letter of Medical Necessity (depending on diagnosis), to be able to verify eligibility and payment for this treatment through patients Medicare and/or other insurance plan.

Patient's Name _____HT:____Weight: ____ Allergies_____

Diagnosis: **ICD-10 E74.02) Pompe's Disease (Glycogenosis)**

ORDERS:

Obtain weight each visit. Vital Signs every 30 minutes beginning with start of infusion and with each rate change, at completion of infusion and after 1 hour wait. Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient response to therapy. Utilize existing central line for administration, or initiate a peripheral IV with each infusion, prn. Normal Saline Flush 3-10 ml before and after infusion, followed by Heparin 100 units/ml 1 – 5 ml per line type. Pump, tubing, and supplies needed to complete prescribed therapy.

If adverse drug reaction, Implement the Standing Adverse Reaction protocol.

Drug:

Lumizyme: _____ Mg in _____ ml 0.9% Normal Saline, every____Wks

Rate of infusion as follows:

Step 1_____/hr x 30 mins Step 2_____/hr x 30 mins

Step 3_____/hr x 30 mins Step 4_____/hr x 30 mins

Lab Orders:

IGG level every 3 months or:_____(specify frequency)

Pharmacist to perform clinical drug monitoring.

(No Stamped Signatures please)

Physicians Signature:_____/_____ Date:_____

(Dispense as written) (Substitution Permitted)

Print Physician Name:_____

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION TO:

866-872-8920

Revised 10/22/2015