Palmetto Infusion Services

Phone: 800-809-1265

MRN:____________________

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______________

Primary Diagnosis:__**Pompe's Disease**___Secondary Diagnosis: ____________________

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 5 ml before and 20 ml flush thru tubing after infusion followed by Heparin Lock 1-5ml 100 units/ml as needed 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

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