MRN:_____
DOB:_____

Standard Plan of Treatment for

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_____**Height:**_____**Weight:**_____

Allergies: _____

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

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

Print Physician Name:_____

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.