MRN:_____

DOB:_____

STANDARD VIMIZIM® (elosulfase alfa) PLAN OF TREATMENT

NOTE: Patient ***may be ineligible*** to receive treatment if they present with symptoms of acute febrile respiratory illness or suspected infection due to the higher risk of life-threatening complications from hypersensitivity reactions.

1. Patient Name:_____ Height (inches):_____ Weight (lbs):_____

2. Allergies: _____

3. Diagnosis: □ **E76.210 Mucopolysaccharidosis type IVA (MPS IVA; Morquio A Syndrome)**

□ Other **ICD-10 code:**_____ **Diagnosis description:** _____

4. Pre-medications: ***Administered 30 to 60 minutes prior to infusion as selected:***

****Product information suggests premedication of antihistamines (with or without antipyretics).***

Acetaminophen_____mg PO; Diphenhydramine:_____mg PO or_____mg IV

Pre-medicate with other: _____

5. Orders: VIMIZIM® (elosulfase alfa) 2 mg/kg IV using a 0.22-micron filter infused as selected:

□ If weight less than 25 kg: dilute in 100 ml 0.9% Sodium Chloride over minimum of 3.5 hours every (1) week. Start infusion at a rate of 3 ml/hr for the first 15 minutes. If tolerated, rate can increase in increments of 6 ml/hr every 15 minutes for a maximum infusion rate of 36 ml/hr.

□ If weight 25 kg or more: dilute in 250 ml 0.9% Sodium Chloride over minimum of 4.5 hours every (1) week. Start infusion at a rate of 6 ml/hr for the first 15 minutes. If tolerated, rate can increase in increments of 12 ml/hr every 15 minutes for a maximum infusion rate of 72 ml/hr.

Special orders: _____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

6. Physician's Signature:_____/_____ Date: _____

No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials:_____ NPI: _____

MRN:_____

Phone: 1-888-410-0317 Fax: 1-866-990-3192

DOB:_____

Guidelines for Prescribing VIMIZIM® (elosulfase alfa)

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:** _____

☐ Include signed and completed **Plan of Treatment**.

☐ Include patient demographic information and insurance information. (Copy of insurance cards if available)

☐ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Please include clinical documentation to support diagnosis.**

- Vimizim® is a hydrolytic lysosomal glycosaminoglycan (GAG)-specific enzyme indicated for patients with Mucopolysaccharidosis type IVA (MPS IVA; Morquio A syndrome).

☐ Other as requested: _____

_____

_____

_____

_____

** **Warnings/Precautions:** **Anaphylaxis and Hypersensitivity Reactions:** Life-threatening anaphylaxis and hypersensitivity reactions have been observed in some patients during treatment with Vimizim. If anaphylaxis or severe hypersensitivity reactions occur, immediately stop the infusion and initiate appropriate medical treatment. Pre-treatment with antihistamines with or without antipyretics is recommended prior to the start of infusion. **Risk of Acute Respiratory Complications:** Patients with acute febrile or respiratory illness may be at higher risk of life-threatening complications from hypersensitivity reactions. Careful consideration should be given to the patient's clinical status prior to administration of Vimizim and consider delaying the Vimizim infusion. The most common adverse reactions (≥10% in Vimizim patients and occurring at a higher incidence than placebo-treated patients) were pyrexia, vomiting, headache, nausea, abdominal pain, chills, and fatigue. **Pregnancy/Breastfeeding:** Discuss Pregnancy or breastfeeding plans/risks prior to start of therapy. See full prescribing information

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.