MRN:_____

DOB:_____

STANDARD NEXVIAZYME™ (avalglucosidase alfa-ngpt) PLAN OF TREATMENT

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 patient's Medicare and/or other insurance plans.

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

2.Allergies: _____

3. Diagnosis: □ E74. 02: Pompe disease

□ Other ICD-10 Code:_____ Diagnosis description:_____

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

**** Premedication of an antihistamine, antipyretic and/ or corticosteroid is suggested prior to infusion***

Acetaminophen:	**Diphenhydramine:** ☐25 mg IVP, □ 50mg IVP, □ 25 mg PO, □ 50mg PO or
□ 650 mg PO	Alternate oral antihistamine to diphenhydramine:
□ 500 mg PO	☐Cetirizine 10 mg □ Loratadine 10 mg Fexofenadine □ 60mgs or □ 180mgs
□ 325 mg PO	**Methylprednisolone:** □ 125 mg IVP □ 40 mg IVP or other_____mg IVP
□ 1000 mg PO	Famotidine: □ 20mg PO, □ 40mg PO, □ 20mg IVP, □ 40mg IVP

Pre-medicate with other: _____

5. Orders:

NEXVIAZYME™ (avalglucosidase alfa-ngpt) IV as directed to infuse per protocol via pump with 0.22-micron filter, every two weeks. **Flush IV extension with 10ml D5W prior to infusion and flush IV tubing with 25mL D5W post infusion.**

6. Dosing:

□ Patient weight of ≥ 30kg, the recommended dosing is 20mg/kg (of actual body weight) IV in 5% Dextrose every two weeks to be infused over 4 to 5 hours for initial and subsequent infusions.

□ Patient weight of <30kg, the recommended dosing is 40mg/kg (of actual body weight) IV in 5% Dextrose every two weeks to be infused over approximately 7 hours for initial infusion and 5 hours for subsequent infusions.

Special orders: _____

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

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

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

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

8. Fax updated supporting clinical MD notes with each order renewal or change in orders

MRN:_____

DOB:_____

Guidelines for Prescribing NEXVIAZYME™ (avalglucosidase alfa-ngpt)

(Required documentation with all initial referrals)

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

☐ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-8)*

☐ 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. Include any lab results and/or tests to support diagnosis.**

- NEXVIAZYME™ is indicated for treatment for patients 1 year or older with late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency)

☐ Other as requested: _____

_____

** **Warnings/Precautions:** ● **Hypersensitivity Reactions Including Anaphylaxis** Prior to NEXVIAZYME administration, consider pretreating with antihistamines, antipyretics, and/or corticosteroids. If a severe hypersensitivity reaction (e.g., anaphylaxis) occurs, NEXVIAZYME should be discontinued immediately, and appropriate medical treatment should be initiated. If a mild or moderate hypersensitivity reaction occurs, the infusion rate may be slowed or temporarily stopped. ● **Risk of Acute Cardiorespiratory Failure in Susceptible Patients:** Patients susceptible to fluid volume overload, or those with acute underlying respiratory illness or compromised cardiac or respiratory function for whom fluid restriction is indicated may be at risk of serious exacerbation of their cardiac or respiratory status during the NEXVIAZYME infusion. More frequent monitoring of vitals should be performed during NEXVIAZYME infusion in these patients. Some patients may require prolonged observation times. •***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.