Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:	MRN:
☐ New referral ☐ Order change ☐ Order Renewal	
Patient preferred clinic:	

Lumizyme (alglucosidase alfa) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:			Patient's Phone:		
Patient Name:			Address:		
Date of Birth:			City, State, Zip:		
Height in inches:	Weight: LB or KG		Gender:	Allergies: ☐ See list ☐ NDKA	

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐ E74.02 - Pompe's Disease (Glycogenosis)

☐ _____ - Other:

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	
6	

IF NO: PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF YES:

LAST INJECTION DATE:

NEXT INJECTION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

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.

MEDICATION:

☑ Lumizyme (alglucosidase alfa) given IV diluted in _____ml of NS

DOSE:

☐ 20mg/kg

☐ Other:_____

FREQUENCY:

☐ Every 2 weeks

☐ Other:_____

ADMINISTRATION:

☐ To infuse over about 4 hours per step protocol

Initiate at 1 mg/kg/hour. If tolerated, increase by 2 mg/kg/hour every 30 minutes to a maximum rate of 7 mg/kg/hour.

☐ Rate of infusion as follows

Step 1: _____ml/hour Step 2: _____ml/hour

Step 3: _____ml/hour Step 4: _____ml/hour

SPECIAL ORDERS:

☐ _____

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE
Dispense as written/Brand medically necessary	Substitution permitted	