Palmetto INFUSION®

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

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

# Nexviazyme™ (avalglucosidase alfa-ngpt) 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 | ☐ NKDA |

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

| | |
|---|---|
| ☐ | E74. 02 - Pompe disease |
| ☐ | _____- Other:_____ |

| REQUESTED DOCUMENTATION: | | PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE? | |
|---|---|---|---|
| 1 | Insurance information | IF NO: | IF YES: |
| 2 | Most recent History & Physical | PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY: | LAST INFUSION DATE: |
| 3 | Full medication list | | NEXT INFUSION DATE: |
| 4 | Tried and failed therapies | | **IF ORDER CHANGE:** |
| 5 | | | ☐ **Continue current order until insurance approved** |
| 6 | | | |

## 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 patient's Medicare and/or other insurance plans.

**PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED**

*Per FDA labeling premedication with an antihistamine, antipyretic and/ or corticosteroid prior to infusion is suggested

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **IV** | Diphenhydramine | ◯ 25mg | ◯ 50mg | | | | | | |
| | Methylprednisolone | ◯ 40mg | ◯ 125mg | ◯ Other: | | | | | |
| | Famotidine | ◯ 20mg | ◯ 40 mg | | | | | | |
| | Other: | ◯ | | | | | | | |
| **PO** | Acetaminophen | ◯ 325mg | ◯ 500mg | ◯ 650mg | ◯ 1000mg | | | | |
| | Famotidine | ◯ 20mg | ◯ 40mg | | | | | | |
| | Diphenhydramine | ◯ 25mg | ◯ 50mg | | | | | | |
| | Fexofenadine | ◯ 60mg | ◯ 180mg | | | | | | |
| | Cetirizine | ◯ 10mg | | | | | | | |
| | Loratadine | ◯ 10mg | | | | | | | |
| | Other: | ◯ | | | | | | | |

### MEDICATION:

☑ Nexviazyme™ given IV in D5W as directed to infuse per step protocol via pump every two weeks.

**Flush IV extension with 10ml D5W prior to infusion and flush IV tubing with 25mL D5W post infusion.**

### SPECIAL/LAB ORDERS:

◯ _____

_____

### DOSE/FREQUENCY:

◯ Weight of ≥ 30kg: 20mg/kg (of actual body weight) every two weeks to be infused over approximately 4 to 5 hours for initial and subsequent infusions.

◯ Weight of < 30kg: 40mg/kg (of actual body weight) every two weeks to be infused over approximately 7 hours for initial infusion and 5 hours for subsequent infusions.

◯ Other: _____

☑ 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 | |