

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> 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	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Tried and failed therapies	FROM PREVIOUS	IF ORDER CHANGE:
5		THERAPY:	
6			
			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 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		PO	Acetaminophen	325mg	500mg	650mg	1000mg
	Methylprednisolone	40mg	125mg	Other:		Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg		
	Other:					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:

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DOSE/FREQUENCY:

Weight of ≥ 30kg: 20mg/kg (of actual body weight) every two weeks to be infused over 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: _____

<input checked="" type="checkbox"/>	Refills x 12 months unless noted otherwise here:
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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	



Palmetto

INFUSION

Checklist for referrals to Palmetto Infusion:

Fax referral to 1.866.872.8920

- 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**

Palmetto Infusion 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. Palmetto Infusion Call Center 800.809.1265. Thank you for the referral.

www.PalmettoInfusion.com