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Methylprednisolone 40mg 125mg Other: Famotidine 20mg 40 mg Other: DICATION: Nexviazyme™ infused via IV in 100mL-1000mL D5W as directed 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. DEF/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: Other: Famotidine 20mg 40mg Diphenhydramine 25mg 50mg Pexofenadine 60mg 180mg Cetirizine 10mg Other: Other: SPECIAL/LAB ORDERS: SPECIA	er FDA labeling premedic	ation with an a		e, antipyretic and/ or c	orticoste	eroid prior to infusion	is suggested							
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Nexviazyme™ infused via IV in 100mL-1000mL D5W as directed 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. SEE/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:] PO	Fexofenadine	60mg	180mg						
directed 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. DSE/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:						Cetirizine								
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	hours for subsequen	infusions.												
	Other:													
														
														
Refills x 12 months unless noted otherwise here:						Dofille v 10 marth	o unione set	od othornic	o horo:					
ELISE /CADE ORDERS														

2	Most recent History & Physical				PLEASE STATE		LAST INFUSION DATE:						
3	Full medication list			REQUIRED WASHOUT	NEXT INFUSION DATE:								
4	Tried and failed therapies			THERAPY:	ROM PREVIOUS IF ORDER CHANGE:								
5							6 (1		4.1				
6					1		Continue cu	rrent oraei	r until ins	urance ap	provea		
MED	ICATION ORDERS:												
L	We may require MD office r	note	s and may	require a lette	er of Medical Necessity (d	lepending	on diagnosis), to be able	to verify eligibilit	y and paymen	t for this treatme	ent through		
patient'	s Medicare and/or other insu	uran	ce plans.										
	DICATION TO BE ADMINI												
*Per F	DA labeling premedicati	on '			e, antipyretic and/ or co	orticoste	eroid prior to infusion is	suggested					
	Diphenhydramine		25mg	50mg			Acetaminophen	325mg	500mg	650mg	1000mg		
lıv	Methylprednisolone		40mg	125mg	Other:		Famotidine	20mg	40mg				
IV	Famotidine		20mg	40 mg			Diphenhydramine	25mg	50mg				
	Other:		•		•	PO	Fexofenadine	60mg	180mg				
MED	ICATION:		•			1	Cetirizine	10mg					
_	Nexviazyme™ infuse	d v	ia IV in	100mL-10	00mL D5W as		Loratadine	10mg					
	directed per step pro						Other:	1 3					
	Flush IV extension w		-			SPFC	IAL/LAB ORDERS:						
	and flush IV tubing			•		5. 20	7						
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	Weight of ≥ 30kg: 20mg to be infused over appro												
	subsequent infusions.	JXIII	natery 4 t	o o nours ic	i ilillai allu								
	Weight of < 30kg: 40mg												
	to be infused over appro			nours for init	ial infusion and 5								
	hours for subsequent in	TUSI	ions.										
	Other:												
					 -								
							Refills x 12 months	unless note	d otherwise	e here:			
LINE USE/CARE ORDERS:							ADVERSE REACTION & ANAPHYLAXIS ORDERS:						
	Start PIV/Access CV						Administer acute infusion and anaphylaxis						
<u>▼</u>							medications per Palmetto Infusion standing adverse						
	Flush device per facility standard flushing procedure						设置资料的基本的						
	Provide nursing care per Palmetto Infusion Nursing Procedures post procedure observation if indicated						scan here.	iich can be i	Juliu at oui	WODSILC			
				dicated			odan noro:						
PRES	CRIBER INFORMAT	ГΙΟ	N:										
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	Dispense as wri	ιιer	i/Brand	medically	necessary			Substitution	permitted				



Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

Patient demographics - a	ddress, p	hone n	umber, S	S#, etc.
Insurance information – co	opy of th	e card(s	s) if poss	ible
Plan of Treatment/Orders				
Most recent physician offi failed therapies – all insur pre–authorization require Medicare/Medicaid HMO	ance cor	mpanies	that red	
Any lab results or other dis support the diagnosis.	agnostic	proced	ures to	

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 patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.PalmettoInfusion.com