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:

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

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO:	IF YES:
PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
	NEXT INFUSION 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 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™ 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.

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: ____
____

SPECIAL/LAB ORDERS:

☐ ____
____

Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC
☑ Flush device per facility standard flushing procedure
☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

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	