



**LUMIZYME® (ALGLUCOSIDASE ALFA) ORDER FORM**

(\* - Required Fields)

New Referral     Order Renewal     Medication/Order Change  
 Benefits Verification Only     Discontinuation Order

**PATIENT INFORMATION**

NAME*:	DOB*:	SEX: M F
ADDRESS:	PHONE:	
WEIGHT: LBS KG	HEIGHT:	EMAIL:
ALLERGIES:		

**PHYSICIAN INFORMATION**

PHYSICIAN NAME*:	PRACTICE NAME:
ADDRESS:	OFFICE CONTACT*:
PHONE:	FAX:
EMAIL (FOR UPDATES):	

**LUMIZYME ORDER\***

(SELECT ONE OF THE FOLLOWING)

ICD-10\*: \_\_\_\_\_

\_\_\_ Dosing: 20mg/kg IV every 2 weeks

Physician Signature\* \_\_\_\_\_ Date\*(Order is Valid for One Year) \_\_\_\_\_  
*Infusion will be administered per MPP policy and protocols*

**REQUIRED DIAGNOSIS:**

\_\_\_ Pompe Disease  
\_\_\_ Other \_\_\_\_\_

**REQUIRED DOCUMENTATION CHECKLIST:**

\_\_\_ Patient Demographics  
\_\_\_ Insurance Card/Information  
\_\_\_ Clinical/Progress Notes supporting DX  
\_\_\_ Current Medication List and H&P

Last Infusion/Injection Date: \_\_\_\_\_

**STANDING LAB ORDERS:** \_\_\_ CMP \_\_\_ CBC \_\_\_ CRP \_\_\_ ESRP \_\_\_ HFR \_\_\_ UA

\_\_\_ Labs to be drawn by Infusion Center    Frequency \_\_\_\_\_

**NOTES/ADDITIONAL COMMENTS:**

**Locations:**

-----**Colorado**-----

\_\_\_ Lakewood

-----**Florida**-----

\_\_\_ Fort Myers Coming Soon  
\_\_\_ Jacksonville  
\_\_\_ Kissimmee Coming Soon  
\_\_\_ Port St. Lucie Coming Soon  
\_\_\_ Winter Park Coming Soon

-----**Texas**-----

\_\_\_ Arlington  
\_\_\_ Dallas  
\_\_\_ Denton  
\_\_\_ Duncanville  
\_\_\_ Ft. Worth Coming Soon  
\_\_\_ Irving  
\_\_\_ Rockwall Coming Soon  
\_\_\_ Southlake  
\_\_\_ Lewisville  
\_\_\_ Plano  
\_\_\_ Tyler