



LUMIZYME® (ALGLUCOSIDASE ALFA) ORDER FORM

(* - Required Fields)

 STAT REQUEST

(*REASON MUST BE PROVIDED BELOW)

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):	

<p>LUMIZYME ORDER*: <i>(SELECT ONE OF THE FOLLOWING)</i></p> <p><input type="checkbox"/> Dosing: 20mg/kg IV every 2 weeks</p>	<p>ICD-10*: _____</p>
<p>Physician Signature* _____</p>	<p>Date*(Order is Valid for One Year) _____ <i>Infusion will be administered per MPP policy and protocols</i></p>

REQUIRED DIAGNOSIS:

Pompe Disease

Other _____

***STAT REASON:**
(STAT request will be assessed per MPP policy and protocol)

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

Labs to be drawn by Infusion Center Frequency _____

NOTES/ADDITIONAL COMMENTS:

Locations:

-----Colorado-----

Lakewood

-----Florida-----

- Jacksonville
- Kissimmee
- Port St. Lucie
- Winter Park

-----Texas-----

- Arlington
- Cedar Hill
- Dallas
- Denton
- Ft. Worth
- Irving
- Rockwall
- Southlake
- Flower Mound
- Plano
- Tyler