



LUMIZYME® (ALGLUCOSIDASE ALFA) ORDER FORM

(* - Required Fields)

<input type="checkbox"/> New Referral	<input type="checkbox"/> Order Renewal	<input type="checkbox"/> Medication/Order Change
<input type="checkbox"/> Benefits Verification Only	<input type="checkbox"/> 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><u>LUMIZYME ORDER*</u> <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* _____ Date*(Order is Valid for One Year) _____ <i>Infusion will be administered per MPP policy and protocols</i></p>	

REQUIRED DIAGNOSIS:
<input type="checkbox"/> Pompe Disease
<input type="checkbox"/> Other _____

REQUIRED DOCUMENTATION CHECKLIST:
<input type="checkbox"/> Patient Demographics
<input type="checkbox"/> Insurance Card/Information
<input type="checkbox"/> Clinical/Progress Notes supporting DX
<input type="checkbox"/> Current Medication List and H&P
Last Infusion/Injection Date: _____

<p>STANDING LAB ORDERS: <input type="checkbox"/> CMP <input type="checkbox"/> CBC <input type="checkbox"/> CRP <input type="checkbox"/> ESRP <input type="checkbox"/> HFR <input type="checkbox"/> UA</p> <p><input type="checkbox"/> Labs to be drawn by Infusion Center Frequency _____</p>

<p>NOTES/ADDITIONAL COMMENTS:</p>
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Locations:

-----Colorado-----

Lakewood

-----Florida-----

Fort Myers Coming Soon

Jacksonville

Kissimmee Coming Soon

Port St. Lucie

Winter Park

-----Texas-----

Arlington

Cedar Hill

Dallas

Denton

Ft. Worth Coming Soon

Irving

Rockwall

Southlake

Lewisville

Plano

Tyler

REVISION DATE- 11/2019