Alglucosidase alfa-ngpt (Nexviazyme)

Provider Order Form rev. 10/30/2023

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Late-onset Pompe disease:

Other: Description:

THERAPY ADMINISTRATION

☐ Administer Nexviazyme for pts weighing great than or equal to 30kg: Infuse 20mg/kg = _____ mg IV every 2 weeks.

☐ Administer Nexviazyme for pts weighing less than 30kg: Infuse 40mg/kg = _____ mg IV every 2 weeks

DOSING & ADMINISTRATION INFORMATION

Patient Weight Range (kg)	Total Infusion Volume (mL) of D5W for 20 mg/kg	Total Infusion Volume (mL) of D5W for 40 mg/kg
5 to 9.9kg	N/A	100ml
10 to 19.9kg	N/A	200ml
20 to 29.9kg	N/A	300ml
30 to 34.9kg	200ml	N/A
35 to 49.9kg	250ml	N/A
50 to 59.9kg	300ml	N/A
60 to 99.9kg	500ml	N/A
100 to 119.9kg	600ml	N/A
120 to 140kg	700ml	N/A

LABORATORY ORDERS

☐ Other: _____

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO
☐ Solumedrol ☐ 40mg / ☐ 125mg IVP
☐ Loratadine 10mg PO
☐ Pepcid 20mg ☐ PO / ☐ IVP
☑ Benadryl ☐ 25 mg / ☐ 50mg ☐ PO / ☐ IV ***(required per PI)***
☐ Other: _____

NURSING

☑ Hold infusion and notify provider for previous adverse reaction to enzyme product.
☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation.

ADDITIONAL ORDERS

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.