

Patient Name: _____

DOB: _____ Wt(kg): _____

Allergies: _____ Phone: _____

LUMIZYME (ALGLUCOSIDASE ALFA) INFUSION ORDERS

REQUIRED INFORMATION

- This signed order form from the provider
- Patient demographics & insurance information
- Clinical/Progress Notes** supporting primary diagnosis
- Baseline Liver enzymes

Patient Name:	DOB:
Allergies:	Patient Phone:

Diagnosis:

- Pompe Disease (ICD-10: _____)

J Code: J0221

LUMIZYME ORDERS

- 20 mg/kg IV every 2 weeks

Patient Wt. _____ kg

Premedications: Tylenol 1000 mg PO

Benadryl 25 mg PO

Solumedrol _____ mg

Other: _____

Prescriber to monitor periodic urinalysis, LFTs, and antibody formation.

****Once we receive all necessary documentation, we will schedule the patient's treatment.**

Additional Instructions:

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Physician Name:	Phone:	Fax:
**Physician Signature:	Date:	