FUSE INFUSION

175MemorialHighway.Suite1-1
NewRochelle,NY
1080

914-460-489
fuse@fuseinfusion.com
914-460-4571

☐ _____ ok the switch to biosimilar if insurance formulary prefers

Alglucosidase alfa (Lumizyme)
Provider Order Form

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS

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

PHYSICIAN INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:

LABORATORY ORDERS

- ☐ CBC ☐ at each dose ☐ every _____
- ☐ CMP ☐ at each dose ☐ every _____
- ☐ CRP ☐ at each dose ☐ every _____
- ☐ Other: _____

PRE-MEDICATION ORDERS

- ☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg IV
- ☐ cetirizine (Zyrtec) 10mg IV
- ☐ loratadine (Claritin) 10mg IV
- ☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
- ☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
- ☐ Other: _____

Dose: _____ Route: _____

Frequency: _____

SPECIAL INSTRUCTIONS

THERAPY ADMINISTRATION

- ☑ **Alglucosidase alfa** (Lumizyme) in 0.9% sodium chloride, intravenous infusion, final concentration of 0.5 to 4mg/ml, administer with 0.2 micron filter
  - Dose: ☐ 20mg/kg / ☐ other _____
  - Frequency: ☐ every 2 weeks
  - Administer over approximately 4 hours, in a step wise manner. Initial infusion rate should be no more than 1mg/k g/hr. Infusion rate may be increased by 2mg/kg/hr every 30 minutes after patient tolerance is established. Max rate is 7mg/kg/hr. If the patient is stable, alglucosidase alfa may be administered at the maximum rate of 7mg/kg/hr until the infusion is completed
- ☑ Flush with 0.9% sodium chloride at the completion of infusion
- ☐ Patient is required to stay for 30-minute observation period
- ☐ Patient is NOT required to stay for observation time
- ☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
  (if not indicated order will expire one year from date signed)

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____