AYSA
THERAPEUTICS INFUSION

NEXVIAZYME ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: ______________________ DOB: ____________ Phone: ______________

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

Diagnosis: ☐ Pompe Disease ICD-10 Code: ____________

☐ Other______________ ICD-10 Code: ____________

Patient Weight: __________ lbs.

Allergies: ____

☐ Clinical/ Progress note, labs, and test supporting primary diagnosis attached

Lab Orders: ____

NEXVIAZYME ORDERS

Nexviazyme

☐ 20mg/kg IV every 2 weeks

☐ Other Dosage:__________________

Pre-Medication

☐ Tylenol 1000mg PO

☐ Benadryl 25 mg PO

☐ Solumedrol __________mg

☐ Other: ________________

ADDITIONAL ORDERS/COMMENTS

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc*., and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: ____________________ Physician Name: ____________________ Date: __________

Phone: __________________ Fax: __________________ Contact Person: ______________________

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