



AYSAs

THERAPEUTICS INFUSION

LUMIZYME (ALGLUCOSIDASE ALFA)

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: _____

Patient Weight: _____ lbs.

Allergies: _____

Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis attached

Baseline Liver enzymes

Labs: Required labs to be drawn by: Infusion Clinic Referring Physician

Lab Orders: _____

LUMIZYME ORDERS

Lumizyme 20mg/kg every 2 weeks

- Premedications:**
- Tylenol 1000mg PO
 - Benadryl 25mg 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 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: _____

ATYOURSERVICEANESTHESIA.COM

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately. If you have received this in error, destroy the document immediately.