

Lumizyme® (alglucosidase alfa) Referral Form



www.biohealthic.com | info@biohealthic.com

PATIENT INFORMATION

Referral Status:

New Referral

Updated Order

Order Renewal

DOB:	Patient Name:	Patient Phone:	
Patient Address:		Patient Email:	
NKDA Allergies:	Weight (lbs/kg):	Height:	
ICD-10 code (required):	ICD-10 description:	Last Treatment Date:	Last 4 SSN:

PROVIDER INFORMATION

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

NURSING

Infusion to be administered per BioHealth protocols.

LUMIZYME THERAPY ADMINISTRATION

20 mg/kg IV every 2 weeks

LABORATORY ORDERS

CBC At each dose Every _____
 CMP At each dose Every _____
 CRP At each dose Every _____
 OTHER _____

REQUIRED DOCUMENTATION

PREMEDICATIONS

acetaminophen (Tylenol) 500 mg 650 mg 10000 mg PO
 cetirizine (Zyrtec) 10mg PO
 loratadine (Claritin) 10mg PO
 diphenhydramine (Benadryl) 25 mg 50 mg PO IV
 methylprednisolone (Solu-Medrol) 40mg 125mg IV
 hydrocortisone (Solu-Cortef) 100mg IV
 Other: _____
 Dose: _____ Route: _____

Patient Demographics

Insurance Card/Information

Progress Notes Supporting DX

Current Medication List and H&P

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Provider Name (Print)	Provider Signature	Date
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<p>Have a Question? (786)460-6044 Fax Referral Form To: (786)219-3917 8684 SUNSET DRIVE MIAMI FL 33143</p>
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