RESTORE HEALTH
INFUSION AND WELLNESS

NEXVIAZYME

Please include the following to expedite the order:
Patient Demographics, Insurance Information, Labs

PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Name: _____ **DOB:** _____ **Gender:** ☐ M ☐ F ☐ Other _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

PRESCRIBER

Name: _____ **DEA:** _____ **NPI:** _____ **State License:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

CLINICAL

Diagnosis: ☐ E74.02 (Pompe Disease)

Allergies: _____ **Weight:** _____ ☐ kg ☐ lbs **Height:** _____ ☐ cm ☐ in

Baseline Labs Completed: ☐ CBC ☐ CMP ☐ AST/LFTs

TREATMENT

NEXVIAZYME (avalglucosidase alfa-ngpt)

Route: Intravenous Infusion

Dose:

- ☐ ≥ 30kg: 20mg/kg
- ☐ ≤ 30kg: 40mg/kg
- ■ Flush with 5% Detrose at infusion completion

Frequency:

- ☐ Every two weeks

Quantity: _____ **Refills:** _____

Premedication Protocol:

- ☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV
- ☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO
- ☐ Other: _____

Sig: _____

■ *Center will use anaphylactic and hypersensitivity protocol established by Restore Health*

Special Instructions: _____

Provider Signature: _____ Date: _____