

Nexviazyme (alglucosidase alfa-ngpt) Referral Form



Patient Preferred Clinic (select one):

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 Vivo protocols.

LABORATORY ORDERS

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

PREMEDICATIONS

acetaminophen (Tylenol) 500 mg 650 mg 1000 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: _____

NEXVIAZYME THERAPY ADMINISTRATION

Greater than or equal to 30 kg: 20 mg/kg every 2 weeks

Less than or equal to 30 kg: 40mg/kg every 2 weeks

REQUIRED DOCUMENTATION

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

Fax Numbers

| | | |
|------------------------|--------------------------|-----------------------------|
| Virginia: 804-500-5941 | Nevada: 702-489-5744 | Massachusetts: 800-540-1852 |
| Colorado: 303-418-4679 | New Jersey: 609-955-3711 | Pennsylvania: 215-399-9244 |
| Florida: 904-930-4211 | Ohio: 216-400-0674 | New York: 800-540-1852 |
| Texas: 469-340-0044 | Oklahoma: 918-770-4421 | Connecticut: 203-724-4838 |

Have a Question? (720) 902-4111
Email Referrals To: referrals@vivoinfusion.com
Email Specialty Referrals to: info@specialtyinfusion.com

Revision Date 4/2024