

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX Handwritten forms will not be accepted.

PATIENT INFORMATION			
Name: _____			DOB: _____
Allergies: _____		Date of Referral: _____	
REFERRAL STATUS			
<input type="checkbox"/> New Referral		<input type="checkbox"/> Dose or Frequency Change	
<input type="checkbox"/> Order Renewal			
INFUSION OFFICE PREFERENCES (Optional)			
Preferred Location* <input type="checkbox"/> Mattoon		<input type="checkbox"/> Effingham	
*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.			
Diagnosis and ICD 10 CODE			
<input type="checkbox"/> Pompe Disease		ICD 10 Code: E74.02	
<input type="checkbox"/> Other _____		ICD 10 Code: _____	
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)			
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Current Medication List <input type="checkbox"/> Labs and tests supporting primary diagnosis <small>*Patient may be required to submit a pregnancy test prior to treatment</small>		<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis (must be within 1 yr) <input type="checkbox"/> Confirmed GAA gene mutation by genetic testing <input type="checkbox"/> Laboratory Test demonstrating deficient alpha-glucosidase activity	
List Tried & Failed Therapies, including duration of treatment:			
1) _____			
2) _____			
MEDICATION ORDERS			
Dosing Wt for Calculations		Ht: _____	BMI: _____
		Wt (in kg): _____	
Dosing	<input type="checkbox"/> J0219 Nexviazyme 20mg/kg IV every 2 weeks <input type="checkbox"/> Other: _____ mg IV every 2 weeks		
Duration	<input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses		
PREMEDICATIONS			
<input type="checkbox"/> Tylenol _____ mg PO <input type="checkbox"/> Benadryl _____ mg PO or IV <input type="checkbox"/> Solumedrol _____ mg IV <input type="checkbox"/> Other: _____			
ADDITIONAL ORDERS / INFORMATION			
Lab Orders to be drawn at time of infusion: _____		Lab Frequency: <input type="checkbox"/> Monthly <input type="checkbox"/> Other: _____	
PRESCRIBER INFORMATION			
Prescriber name : _____			
Office Phone: _____		Office Fax: _____	Office Email: _____
Prescriber Signature: _____		Date: _____	Time: _____

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
 Fax Completed Form and all documentation to:

MATTOON
 1000 Health Center Dr. Ph. 217-258-4150
 Suite 204 Fax 217-348-2579
 Mattoon, IL 61938

EFFINGHAM
 901 Medical Park Dr. Ph. 217-342-7500
 Suite 201 Fax 217-342-7499
 Effingham, IL 62401