

LAMZEDE (VELMANASE ALFA-TYCV) ORDER FORM**PATIENT INFORMATION**

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____ kg

Allergies: _____

☐ Patient has known difficult venous access. Comments: _____**DIAGNOSIS** (Provider must specify)☐ Non-central nervous system manifestations of alpha-mannosidosis in adult and pediatric patients, ICD 10: E77.1☐ Other: _____**PROVIDER INFORMATION**

Provider Name (print name): _____ Provider NPI: _____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:☐ Demographics☐ Labs and tests supporting diagnosis☐ Office/progress notes**PRE-MEDICATION** (Not typically indicated)☐ Acetaminophen (Tylenol) 500 mg PO☐ Famotidine 20 mg IV☐ Methylprednisolone

(Solu-Medrol) 125 mg IVP

☐ Benadryl 25mg PO☐ Cetirizine (Zyrtec) 10 mg PO☐ Other: _____ Dose: _____ Route: _____**MEDICATION**

MEDICATION	DOSE	ROUTE	FREQUENCY
Lamzede	1 mg/kg (actual body weight)	IV	Every week

☐ New Start Therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____**LABS / SPECIAL INSTRUCTIONS**

Order valid for 1 year from date of signature unless otherwise specified here: _____

FAX NUMBERS:☐ CT: 203.433.0621☐ FL: 904.877.9270☐ MA: 413.296.8482☐ MD: 240.224.8607☐ ME: 207.407.7272☐ NC: 919.984.8698☐ NH: 603.217.5371☐ NJ: 201.581.4521☐ NY: 631.250.6020☐ OH: 937.871.4594☐ PA: 610.273.5998☐ SC: 864.973.6279☐ VA: 703.202.0499