INTRAMED Plus
infusion services

LAMZEDE®

INFUSION & MEDICAL CENTER

1. Patient Name ______________________ **DOB** __________ **Patient Phone/Cell #** ______________

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD-10 Code):

Primary Diagnosis:

_____ Alpha-mannosidosis ICD-10 Code: E77.1

_____ Other: ______________________ ICD-10 Code: __________

Allergies: ______________________ (or attach list)

3. Clinical Information — Please fax with Infusion Order Form:

- Clinical documentation supporting primary diagnosis
- Recent Lab/Test Results including:
  - o Urine oligosaccharides
  - o Acid alpha-mannosidase activity in leukocytes
- Medication List

Patient
Weight: _______ lbs.
Height ________ in.

4. Infusion Center – Lab Orders (check order for Infusion Center to manage):

❑ Lab orders: ______________________ Frequency: ______________

LAMZEDE (velmanase alfa-tycv) J Code: J0217

5. Drug Order:

❑ Infuse 1 mg/kg intravenously once weekly

❑ Alternative Dosing: ______________________

____ Refills (Recommend 52 Refills)

Pre-Medication Orders: ______________________

Consider pretreating with antihistamines, antipyretics, and/or corticosteroids prior to LAMZEDE administration

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing our services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

6. Physician Signature: ______________________ / ______________________ Date: ______________

Dispense as written Substitution permitted

Printed Physician's Name with Credentials: ______________________ Phone #: ______________

FAX ALL INFORMATION CENTRAL FAX **803.999.1754**	**INFUSION CENTER LOCATIONS** BERKELEY CHARLESTON COLUMBIA GREENVILLE CENTRAL INTAKE PHONE 803.999.1760

JAN 2024