

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

CENTRAL INTAKE PHONE
803.999.1750