

Patient Information Fax completed form, insurance information and clinical documentation to 515.559.2495.

Patient Name: _____ **DOB:** _____ **Phone:** _____

Patient Status: New to Therapy Continuing Therapy **Next Treatment Date:** _____

Medical Information

Diagnosis: Pompe disease (ICD-10 code: E74.02)

Patient Weight: _____ lbs. (required) **Allergies:** _____

Therapy Order

Lumizyme: 20 mg/kg IV every 2 weeks

Premedications: Tylenol 1000 mg PO
 Benadryl 25 mg PO
 Solu-Medrol _____ mg IV
 Other: _____

Lab Orders: _____ **Lab Frequency:** _____

**Recommended labs: periodic urinalysis, LFTs and antibody formation*

Required labs to be drawn by: Hy-Vee Health Referring Provider

Other Orders: _____

Provider Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ **Signature:** _____ **Date:** _____

Provider NPI: _____ **Phone:** _____ **Fax:** _____ **Contact Person:** _____

Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): _____

Service Areas

Des Moines, IA West Des Moines, IA Chicago, IL Omaha, NE Buffalo, NY Dallas, TX

Phoenix, AZ Other _____

HY-VEEHEALTHINFUSION.COM

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COMPREHENSIVE SUPPORT FOR LUMIZYME THERAPY

Patient Information

Patient Name: _____ DOB: _____

Required Documentation for Referral Processing & Insurance Approval

Include signed and completed order (MD/prescriber to complete page 1)

Include patient demographic information and insurance information

Include patient's medication list

Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits or contraindications to conventional therapy

Confirmation of Pompe disease by one of the following **(please attach)**:

Absence or deficiency of the enzyme acid alpha-glucosidase

Molecular genetic testing showing a deletion or mutation of the GAA gene

Documentation of presence of clinical signs and symptoms of Pompe disease

Include labs and/or test results to support diagnosis

Other Medical Necessity: _____

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

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