Hy-Vee health™

NEXVIAZYME Infusion Orders

PHONE 515.225.2930 | **FAX** 515.559.2495

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)

Other: ______________ (ICD-10 Code: ______________)

Patient Weight: ________ lbs. (required) **Allergies:** ______________________

Therapy Order

Nexviazyme: 20 mg/kg IV every 2 weeks

Other dosage: ______________

Premedication: Tylenol 1000 mg PO

Benadryl 25 mg PO

Solu-Medrol ______________ mg IV

Other: ______________

Lab Orders: ______________ **Lab Frequency:** ______________

Required labs to be drawn by: Infusion Center 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 ______________

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COMPREHENSIVE SUPPORT FOR NEXVIAZYME 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 current 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
- Documentation of presence of clinical signs and symptoms of Pompe disease

Include labs and/or test results to support diagnosis

- Confirmed GAA gene mutation by genetic testing
- Laboratory test demonstrating deficient alpha-glucosidase activity

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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