



MOUNTAIN GRACE
HOME INFUSION

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NEXVIAZYME

Date of order: _____

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Update Order ☐ Order Renewal

Date: _____ Patient Name: _____ Patient Phone: _____ DOB: _____

ICD-10 code (required): ☐ D80. _____ ☐ D81. _____ ☐ D82. _____ ☐ D83. _____ ☐ G61.81

Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: info@managecaresolutions.com

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

NURSING

- ☒ Center will use Hypersensitivity protocol established by Mountain Grace Home Infusion and PI

THERAPY ADMINISTRATION

- ☒ Nexviazyme in 5% Dextrose, Intravenous infusion
Dose: ☐ ≥30 kg: 20mg/kg ☐ ≤30 kg: 40mg/kg
Round the number of vials up to the next whole number
Frequency: Every 2 weeks
- ☒ Flush with 5% Dextrose at completion of infusion
- ☐ Refills: ☐ Zero/ ☐ for 12 months/ ☐ _____
(if not indicated order will expire one year from date signed)
- To receive the brand-name medication, the prescribing provider must clearly write "Brand Medically Necessary" on the prescription. If this notation is absent, 14H may dispense an FDA-approved generic equivalent or biosimilar, when available.*

LABORATORY ORDERS

- ☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other _____ ☐ Frequency _____

☐ Please check this box if you DO NOT authorize Mountain Grace Home Infusion to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

PRE- MEDICATION ORDERS

Pre-meds not usually indicated

- ☐ Diphenhydramine ☐ 25mg / ☐ 50 mg ☐ PO / ☐ IV
☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650 mg ☐ PO
☐ Other: _____
Dose: _____ Route: _____ Frequency: _____

SPECIAL INSTRUCTIONS:

Provider Name (Print) : _____

Provider Signature : _____

Date : _____

Please send it to this email: info@mginfusion.com