LAMZEDE® (VELMANASE ALFA) PRESCRIBER ORDER FORM

Patient Name:	Date of Birth:	Gender:
Address:		
Phone:	**Height:** _____ ☐ inches ☐ cm	**Weight:** _____ ☐ lbs ☐ kg **Date weight obtained:** _____

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:

Allergies: ☐ NKDA OR (List):

LAMZEDE® (Velmanase Alfa) Prescription

Infuse _____ mg (1mg/kg) via IV infusion once weekly

Infusion Rate: _____

< 50kg = minimum 60 minutes

≥ 50kg = 25mL/hr maximum rate

Flush IV line with 10mL Sodium Chloride 0.9% after LAMZEDE infusion is complete. Refill as directed x 1 year

Ancillary Orders

Anaphylaxis Kit

Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg – 25mg max per dose) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Medication Orders

- ☐ Acetaminophen 650 mg orally 30 minutes before infusion.
- ☐ Diphenhydramine 25 mg orally 30 minutes before infusion.
- ☐ Methylprednisolone sodium succinate 40 mg IVP 20 minutes before infusion.
- ☐ Other: _____

IV Flush Orders

- Peripheral: 0.9% Sodium Chloride 3 to 5 mL pre-/post-use.
- Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed. If unable to obtain implanted port access, it is acceptable to establish a peripheral IV access and administer peripherally.

Lab Orders

- ☐ No labs ordered at this time.
- ☐ Other: _____

Skilled nurse to assess and administer via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:		Phone:	Fax:
Address:		**NPI:**	
City, State:	**Zip:**	**Office Contact:**	

Fax completed form, insurance information, and clinical documentation to: 713-983-4647

Not valid for use for patients residing in Arizona, New York, and Wisconsin

