

**NEXVIAZYME® (AVALGLUCOSIDASE ALFA-NGPT) PRESCRIBER ORDER FORM**

Patient Name:		Date of Birth:	Gender:	
Address:				
Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> kg

**Clinical Information**

Primary Diagnosis Description:	ICD-10 Code:
Allergies: <input type="checkbox"/> NKDA OR (List):	

**Avalglucosidase alfa-ngpt (Nexviazyme®) Prescription**

**Avalglucosidase alfa-ngpt (Nexviazyme®) in Dextrose 5% injection. Refill as directed x 1 year**

- $\geq 30$  kg: 20 mg/kg (actual body weight) \_\_\_\_\_ mg IV every 2 weeks
- $< 30$  kg: 40mg/kg (actual body weight) \_\_\_\_\_ mg IV every 2 weeks

Infuse at initial rate of 1mg/kg/hour. If there are no signs of hypersensitivity or infusion related reactions, increase the infusion rate every 30 minutes.

Step 1	Step 2	Step 3	Step 4
1 mg/kg/hour	3 mg/kg/hour	5 mg/kg/hour	7 mg/kg/hour

For 40mg/kg doses, **subsequent infusions** may be infused over 5 hours as per below steps:

Step 1	Step 2	Step 3	Step 4
1 mg/kg/hour	3 mg/kg/hour	6 mg/kg/hour	8 mg/kg/hour

Dispense quantity sufficient of 100 mg single dose vials to prepare required compounded product. Withdraw required amount from vials and discard any unused vial contents.

Administer using 0.2 micron filter. **Do not** flush with 0.9% sodium chloride without first flushing Nexviazyme with 5% dextrose in water.

**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 ( $\leq 30$  kg – 25mg max dose) IV or IM; repeat x 1 in 15 min PRN no improvement.
  - 0.9% Sodium Chloride 500 mL ( $> 30$  kg) or 250 mL ( $\leq 30$  kg) IV at KVO rate PRN anaphylaxis.

**Pre-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: 5% **Dextrose in Water** 3-5mL pre-/post-use. After 5% dextrose flush, flush with 3-5 mL 0.9% sodium chloride. Discontinue peripheral line after completion of infusion.

Other \_\_\_\_\_

**Lab Orders**

\_\_\_\_\_

Skilled nurse to administer doses intravenously. 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:

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