NEXVIAZYME® (AVALGLUCOSIDASE ALFA-NGPT) PRESCRIBER ORDER FORM

Patient Name:	**Date of Birth:**	**Gender:**
Address:		

Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

Allergies: ☐ NKDA OR (List):

Avalgludosidase alfa-ngpt (Nexviazyme®) Prescription

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

☐ > 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 (≤ 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 (≤ 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 Wate**r 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:**

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

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