Palmetto Infusion Services

Phone: 800-809-1265

MRN:_____

DOB: _____

Standard Plan of Treatment for Fabrazyme

(Re)Certification Period from _____ to _____

Note: We may require MD office notes and may require a letter of Medical Necessity (depending on diagnosis), to be able to verify eligibility and payment for this treatment through patients Medicare and/or other insurance plan.

Patient's Name _____ HT: _____ Weight: _____ Allergies: _____

Primary Diagnosis:

☐ 272.7 Fabrys Disease ☐ Other: _____

Orders:

Obtain weight each visit. Vital Signs baseline, 15 minutes after start of infusion, then every hour until complete, then 30 minute post infusion for the first 3 doses. Post infusion wait for first 3 doses, and then patient may be discharged after infusion completed. Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient response to therapy.
Utilize existing central line for administration, or initiate a peripheral IV with each infusion, prn
Normal Saline Flush 5 ml before and 20 ml flush thru tubing after infusion followed by Heparin Lock 1 - 5ml 100 units/ml as needed per line type.
Pump, tubing, and supplies needed to complete prescribed therapy.
If adverse drug reaction, Implement the Standing Adverse Reaction protocol.

Premedication:

☐ None
☐ 500 mg Acetaminophen PO 30 minutes prior to infusion
☐ Other: _____

Dose:

Fabrazyme: _____ mg in 250 ml 0.9% Normal Saline IV every 2 weeks

Lab Orders:

Plasma GL-3 and antibody testing to be drawn initially, then every 3 months for the first 18 months of therapy.

Other:

Pharmacist to perform clinical drug monitoring

(No Stamped Signatures Please)

Physicians Signature: _____ _____ Date: _____
(Dispense as written) (Substitution Permitted)

Print Physician Name: _____

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION TO 866-872-8920