Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Fabrazyme® (agalsidase beta) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:				Patient's Phone:			
Patient Name:				Address:			
Date of Birth:				City, State, Zip:			
Height in inches:	Weight:	LB or	KG	Gender:	Allergies:	☐ See list	☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐ E75.21 - Fabry Disease

☐ _____ - Other: _____

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	Serum IgG and GL-3 level		☐ **Continue current order until insurance approved**
6			

MEDICATION ORDERS:

NOTE: We may require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for this treatment through Medicare and/or other insurance plans.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

*FDA labeling suggests pre-medication with an antihistamine and antipyretic in patients who experience infusion reactions.

IV	Diphenhydramine	◯ 25mg	◯ 50mg				
	Methylprednisolone	◯ 40mg	◯ 125mg	◯ Other:			
	Famotidine	◯ 20mg	◯ 40 mg				
	Other:	◯					

PO	Acetaminophen	◯ 325mg	◯ 500mg	◯ 650mg	◯ 1000mg
	Famotidine	◯ 20mg	◯ 40mg		
	Diphenhydramine	◯ 25mg	◯ 50mg		
	Fexofenadine	◯ 60mg	◯ 180mg		
	Cetirizine	◯ 10mg			
	Loratadine	◯ 10mg			
	Other:	◯			

MEDICATION:

☑ Fabrazyme® (agalsidase beta) IV in 50 -- 500mL of NS

Patients ≥ 30kg: Initial infusion should be administered at 15mg/hr. Increase in increments of 3-5mg/hr with subsequent infusions as tolerated, with a minimum infusion time of 1.5hr.

Patients weighing < 30kg: Infuse at a maximum rate of 15mg/hr.

SPECIAL/LAB ORDERS:

◯ _____

_____

DOSE:

◯ 1mg/kg

◯ Other: _____

FREQUENCY:

◯ Every 2 weeks

◯ Other: _____

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:		PHONE:	
ADDRESS:		FAX:	
CITY, STATE, ZIP:		NPI:	

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE:
Dispense as written/Brand medically necessary	Substitution Permitted	