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 | Current infusion rate (established patients) | | |

## 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
After completion of infusion, flush line with 20ml 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:

## NURSING ORDERS:

☑ Start PIV/Access CVC
☑ Flush device per facility standard flushing procedure
☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated.

## 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 | |