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

Rev. 4.28.25

Elfabrio® (pegunigalsidase alfa-iwxj) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Patient Name:			
Patient's Phone:		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 antihistamines, antipyretics, and/or cortosteriods if patient received with previous therapy and may be considered with treatment naïve patients.

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:	☐				

Initial 4-6 Infusion Rates

Volume and Rate for Enzyme Naïve Patients		
Actual Body Weight	Volume	Infusion Rate
<70kg	150ml	37.5ml/hr
70-100kg	250ml	60ml/hr
>100kg	500ml	83ml/hr

Volume and Rate for Enzyme Experienced Patients		
Actual Body Weight	Volume	Infusion Rate
<70kg	150ml	50ml/hr
70-100kg	250ml	83m/hr
>100kg	500ml	167ml/hr
If patient infusion duration over 3 hours from previous treatment use the same rate for Elfabrio®		

MAINTENANCE INFUSION RATES:

***If patient tolerates the initial 4-6 infusions, the duration may be decreased by 30 minutes every 3rd infusion.**

***Minimum maintenance infusion duration is 1.5 hours.**

MEDICATION:

☑ Elfabrio® (pegunigalsidase alfa-iwxj) IV infusion in 150ml to 500ml NS. After completion of infusion, flush line with 20ml of NS at last infusion rate used.

DOSE:

☐ 1mg/kg (based on actual body weight)

☐ Other:_____

FREQUENCY:

☐ Every 2 weeks

☐ Other:_____

SPECIAL/ OTHER LAB ORDERS:

☐ _____

_____

☑ 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.

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	

Palmetto INFUSION

Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- ☐ **Patient demographics - address, phone number, SS#, etc.**
- ☐ **Insurance information - copy of the card(s) if possible**
- ☐ **Plan of Treatment/Orders**
- ☐ **Most recent physician office notes to include tried and failed therapies - all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- ☐ **Any lab results or other diagnostic procedures to support the diagnosis.**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.palmettoinfusion.com