

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

Fabrazyme® (agalsidase beta) Standard Plan of Treatment

Rev 4.28.25

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 LAST INFUSION DATE:
3 Full medication list	REQUIRED WASHOUT FROM PREVIOUS THERAPY: NEXT INFUSION DATE:
4 Tried and failed therapies	IF ORDER CHANGE: <div style="border: 1px solid black; padding: 5px; text-align: center;">Continue current order until insurance approved</div>
5 Serum IgG and GL-3 level	
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	25mg	50mg	Other:	PO	325mg	500mg	650mg	1000mg
Diphenhydramine				Acetaminophen				
Methylprednisolone				Famotidine				
Famotidine				Diphenhydramine				
Other:				Fexofenadine				
				Cetirizine				
				Loratadine				
				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:

FREQUENCY:

Every 2 weeks
 Other: _____

DOSE:

1mg/kg
 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.

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