INTRAMED Plus
infusion services

FABRAZYME®

INFUSION & MEDICAL CENTER

1. _____ _____ _____
Patient Name **DOB** **Patient Phone/Cell #**

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: _____ Fabry Disease ICD-10 Code: E75.21

Allergies: _____(or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes & labs supporting primary diagnosis
- Recent Lab Results including Serum IgG Antibody and GL-3 Levels if available
- Medication List

Patient
Weight: _____ lbs.
Height:_____ in.

4. Infusion Center – Lab Orders: (Check order for Infusion Center to manage):

❑ Obtain Serum IgG Antibodies at baseline and every _____ for the duration of therapy

❑ Obtain GL-3 Levels at baseline and every _____ for the duration of therapy

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FABRAZYME® (agalsidase beta) J Code: J0180

Drug Order:

Administer 1 mg/kg Fabrazyme (_____ mg) IV every two weeks _____# Refills (Recommend 25 Refills)

Pre-Medication Orders:

Acetaminophen PO, Diphenhydramine PO, & methylprednisolone IV

Administered 30 min prior to infusion *Clinical team to dose & adjust to patient's needs

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus
to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name:_____Contact Phone #: _____

FAX ALL INFORMATION **CENTRAL FAX 803.999.1754**	**LOCATIONS** **COLUMBIA CHARLESTON GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1760**