

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 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

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
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