

**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

<b>Patient</b>	
<b>Weight:</b>	_____ lbs.
<b>Height:</b>	_____ 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 #: \_\_\_\_\_

<b>FAX ALL INFORMATION</b> <b>CENTRAL FAX 803.999.1754</b> <b>ALTERNATE FAX 803.999.1887</b>	<b>LOCATIONS</b> <b>COLUMBIA CHARLESTON GREENVILLE</b> <b>CENTRAL INTAKE PHONE 803.999.1960</b>
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