

FABRAZYME

Please include the following to expedite the order:
Patient Demographics, Insurance Information, Labs

PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Name: _____ DOB: _____ Gender: ☐ M ☐ F ☐ Other _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

PRESCRIBER

Name: _____ DEA: _____ NPI: _____ State License: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

CLINICAL

Diagnosis: ☐ E75.21 (Fabry [-Anderson] Disease)

Allergies: _____ Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in

CBC Completed: ☐ Yes ☐ No CMP/LFTs Completed: ☐ Yes ☐ No

TREATMENT

FABRAZYME (agalsidase beta)

Route: Intravenous infusion

Dose: ☐ 1mg/kg

☐ Total dose: _____mg

Frequency:

☐ Once every two weeks

Premedication Protocol:

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO

☐ Methylprednisolone: ☐ 40mg ☐ 125mg IV

☐ Other: _____

Sig: _____

☒ Center will use anaphylactic and hypersensitivity protocol established by Restore Health

Special Instructions: _____

Quantity: _____ Refills: _____

Provider Signature: _____

Date: _____

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