RESTORE HEALTH
INFUSION AND WELLNESS

FABRAZYME

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

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

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

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

PRESCRIBER INFORMATION

Prescriber Name: _____ **DEA:** _____ **NPI:** _____ **State License:** _____

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

Phone: _____ **Fax:** _____

CLINICAL INFORMATION

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

Allergies: _____ **Weight:** _____ ☐Kg ☐Lbs **Height:** _____ ☐cm ☐in

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

TREATMENT INFORMATION

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: _____

Special Instructions: _____

Quantity: _____ **Refills:** _____

Provider Name: _____ Provider Signature: _____ Date: _____

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