Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:	
☐ New referral	☐ Order change	☐ Order Renewal	
Patient preferred clinic:			

Fabrazyme® (agalsidase beta) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:			Patient's Phone:		
Patient Name:			Address:		
Date of Birth:			City, State, Zip:		
Height in inches:	Weight: LB or KG		Gender:	Allergies: ☐ See list ☐ NKDA	

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

	E75.21 - Fabry Disease
	_____ - Other: _____

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	Serum IgG and GL-3 level
6	Current infusion rate (established patients)

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO:

PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF YES:

LAST INFUSION DATE:

NEXT INFUSION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

NOTE: We may require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for this treatment through Medicare and/or other insurance plans.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

*FDA labeling suggests pre-medication with an antihistamine and antipyretic in patients who experience infusion reactions.

IV	Diphenhydramine	☐ 25mg	☐ 50mg						
	Methylprednisolone	☐ 40mg	☐ 125mg	☐ Other:					
	Famotidine	☐ 20mg	☐ 40 mg						
	Other:	☐							
PO	Acetaminophen	☐ 325mg	☐ 500mg	☐ 650mg	☐ 1000mg				
	Famotidine	☐ 20mg	☐ 40mg						
	Diphenhydramine	☐ 25mg	☐ 50mg						
	Fexofenadine	☐ 60mg	☐ 180mg						
	Cetirizine	☐ 10mg							
	Loratadine	☐ 10mg							
	Other:	☐							

MEDICATION:

☑ Fabrazyme® (agalsidase beta) IV in 50 - 500mL

After completion of infusion, flush line with 20ml of NS

Patients ≥ 30kg: Initial infusion should be administered at 15mg/hr. Increase in increments of 3-5mg/hr with subsequent infusions as tolerated, with a minimum infusion time of 1.5hr.

Patients weighing < 30kg: Infuse at a maximum rate of 15mg/hr.

SPECIAL/LAB ORDERS:

☐ _____

_____

DOSE:

☐ 1mg/kg

☐ Other: _____

FREQUENCY:

☐ Every 2 weeks

☐ Other: _____

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:		PHONE:	
ADDRESS:		FAX:	
CITY, STATE, ZIP:		NPI:	

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE:
Dispense as written/Brand medically necessary	Substitution Permitted	