immersiv HEALTH

FABRAZYME® ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

☐ E75.21 Fabry Disease

☐ ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

☐ Insurance Information

☐ List of Medications

☐ Most recent History & Physical

☐ Tried & failed Therapies

☐ Serum IgG & GL-3 Level

MEDICATION ORDER

☑ FABRAZYME (agalsidase beta) 1 mg/kg or _____ mg IV in 50 ml – 500 ml NS with .22m filter

Patients ≥ 30kg: Initial infusion at 15 ml/hr. Increase by increments of 3-5 mg/hr with subsequent infusions as tolerated. Minimum total infusion time of 90 minutes.

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

☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE:

_____

PRE-MEDICATIONS

PO

☐ Acetaminophen: 650 mg

☐ Cetirizine: 10 mg

☐ Diphenhydramine: 25 mg

IV

☐ Methylprednisolone: 125 mg

☐ Diphenhydramine: 25 mg

☐ OTHER: _____ ☐ PO ☐ IV

Patient to be observed for 60 minutes following the first infusion. Administer per protocol.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ **CONTACT NAME:** _____
(IF APPLICABLE)

SIGNATURE: _____ | _____ **DATE:** _____
(NO STAMPS)

SUBSTITUTION PERMITTED DISPENSE AS WRITTEN