INTRAMED Plus
infusion services

ELFABRIO®

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 ICD-10 Code):

Primary Diagnosis:

_____ Fabry Disease — ICD-10 Code: E75.21

_____ Other: ______________________ ICD-10 Code: __________

Allergies: ______________________ (or attach list)

3.Clinical Information — Please fax with Infusion Order Form:

- Clinical documentation supporting primary diagnosis
- Recent Lab/Test Results including:

o Alpha-galactosidase A (alpha-Gal A), genotype

o Plasma globotriaosylsphingosine (lyso-Gb3)

o Baseline serum creatinine and urinary protein to creatinine ratio

- Medication List

Patient
Weight: _______ lbs.
Height ________ in.

ELFABRIO (pegunigalsidase alfa-iwxj) J Code: J2508

4. Drug Order:

❏ Infuse 1 mg/kg intravenously once every two weeks

❏ Alternative Dosing: ______________________

____ Refills (Recommend 26 Refills)

Pre-Medication Orders: ______________________

In ERT-naïve patients, pre-treating with antihistamines, antipyretics, and/or corticosteroids may be considered

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing our 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 with Credentials: ______________________ Phone #: ____________

FAX ALL INFORMATION CENTRAL FAX **803.999.1754**	**INFUSION CENTER LOCATIONS** BERKELEY CHARLESTON COLUMBIA GREENVILLE CENTRAL INTAKE PHONE 803.999.1760

JAN 2024