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 INTAKE PHONE
CENTRAL FAX **803.999.1754**	**803.999.1750**