INTRAMED Plus
infusion services

# FABRAZYME®

## 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 ICD10 Code):**

Primary Diagnosis: _____ Fabry Disease ICD-10 Code: E75.21

Allergies: _____(or attach list)

**3. Clinical Information – Please fax with Infusion Order Form:**

- Clinical MD Notes & labs supporting primary diagnosis
- Recent Lab Results including Serum IgG Antibody and GL-3 Levels if available
- Medication List

**Patient**
**Weight:** _____ lbs.
**Height:**_____ in.

**4. Infusion Center – Lab Orders: (Check order for Infusion Center to manage):**

❑ Obtain Serum IgG Antibodies at baseline and every _____ for the duration of therapy

❑ Obtain GL-3 Levels at baseline and every _____ for the duration of therapy

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### FABRAZYME® (agalsidase beta) J Code: J0180

**Drug Order:**

Administer 1 mg/kg Fabrazyme (_____ mg) IV every two weeks _____# Refills ( ecommend 25 Refills

**Pre-Medication Orders:**

Acetaminophen PO, Diphenhydramine PO, & methylprednisolone IV

Administered 30 min prior to infusion *Clinical team to dose & adjust to patient's needs

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

By signing this form and utilizing these 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:_____Contact Phone #: _____

| FAX ALL INFORMATION | CENTRAL INTAKE PHONE |
|---|---|
| CENTRAL FAX **803.999.1754** | **803.999.1750** |