Agalsidase beta (Fabrazyme)

Provider Order Form rev. 9/27/2021

IVX HEALTH

PATIENT INFORMATION

Date:	Patient Name:	DOB:
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:		Weight lbs/kg:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy	Next Due Date (if applicable):	

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:	
Ordering Provider:	Provider NPI:	
Referring Practice Name:	Phone:	Fax:
Practice Address:	City:	State: Zip Code:

NURSING

☑ Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 09.07.2021)

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

☐ **Agalsidase beta** (Fabrazyme) in 0.9% sodium chloride, intravenous infusion, administer with 0.2 micron filter
- ☐ 1mg/kg / ☐ other _____
- Frequency: ☐ every 2 weeks
- Infuse over one hour
- Initial intravenous infusion rate is no more than 0.25 mg/min (15mg/hr). After tolerance to the infusion is well established, increase the infusion rate in increments of 0.05 to 0.08 mg/min (increments of 3 to 5 mg/hr). Maximum infusion rate for patients weighing less than 30kg is 0.25mg/min (15mg/hr). For patients >30kg, the minimum infusion duration is 1.5 hours.
- ☑ Flush with 0.9% sodium chloride at the completion of infusion

☐ Patient is required to stay for 30-minute observation post infusion
☐ Patient is NOT required to stay for observation time
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

Provider Name (Print) **Provider Signature** **Date**

Email ivxintake@ivxhealth.com or fax this form, insurance card (both sides), demographics, recent H&P, labs, and supporting clinicals to:

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