

# Agalsidase beta (Fabrazyme)



Provider Order Form rev. 10/12/2022

## PATIENT INFORMATION

Referral Status:  New Referral  Updated Order  Order Renewal

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

ICD-10 code (required): \_\_\_\_\_ ICD-10 description: \_\_\_\_\_

NKDA Allergies: \_\_\_\_\_ Weight (lbs/kg): \_\_\_\_\_ Height: \_\_\_\_\_

Patient Status:  New to Therapy  Continuing Therapy Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

## 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](http://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
- hydrocortisone (Solu-Cortef)  100mg 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 infusion completion
- Patient is required to stay for 30-minute observation period
- Refills:  Zero /  for 12 months /  \_\_\_\_\_  
(if not indicated order will expire one year from date signed)

## SPECIAL INSTRUCTIONS

Provider Name (Print) \_\_\_\_\_ Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

### FAX NUMBERS

- |   |   |   |   |   |
|---|---|---|---|---|
| <input type="checkbox"/> BAY AREA: 844-889-0275   | <input type="checkbox"/> CONNECTICUT: 860-955-1532    | <input type="checkbox"/> HARRISBURG: 844-859-4235   | <input type="checkbox"/> PALM BEACH: 561-768-9044   | <input type="checkbox"/> TAMPA: 844-946-0849      |
| <input type="checkbox"/> CHARLOTTE: 336-663-0143  | <input type="checkbox"/> CHICAGO: 312-253-7244        | <input type="checkbox"/> INDIANAPOLIS: 844-983-2028 | <input type="checkbox"/> PHILADELPHIA: 844-820-9641 | <input type="checkbox"/> WEST TN/AR: 888-615-1445 |
| <input type="checkbox"/> CINCINNATI: 844-946-0868 | <input type="checkbox"/> COLUMBUS: 844-627-2675       | <input type="checkbox"/> JACKSONVILLE: 904-212-2338 | <input type="checkbox"/> RALEIGH: 919-287-2551      | <input type="checkbox"/> MIDDLE TN: 888-615-1445  |
|   | <input type="checkbox"/> DAYTONA: 386-259-6096        | <input type="checkbox"/> KANSAS CITY: 844-900-1292  | <input type="checkbox"/> SARASOTA: 941-870-6550     | <input type="checkbox"/> EAST TN: 615-425-7427    |
|   | <input type="checkbox"/> FT. LAUDERDALE: 754-946-2052 | <input type="checkbox"/> ORLANDO: 844-946-0867      | <input type="checkbox"/> SOUTHWEST FL: 813-283-9144 |   |