Dear Provider,

Specialty therapies can be complex, and complete information is essential to help ensure timely access to care.

The following prescriber order form is designed to capture the necessary clinical and patient information the dispensing pharmacy requires to begin the applicable prescribed therapy.

If your patient has elected to use Option Care Health, please fax completed form and required clinical documentation to **713-983-4647**.

Sincerely,
Option Care Health

Fabry's Disease Enzyme Replacement Prescriber Order Form

Patient Name:	**Date of Birth:**	**Gender:**
Address:		

Patient Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs. ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

Is this the first dose? ☐ YES –Date of first dose: ______________ ☐ NO – Last dose: ____________ ☐ # of doses administered _____

TB Status:

- ☐ PPD (negative) – Date: ______________
- ☐ Last chest x-ray – Date: ______________
- ☐ QuantiFERON or T Spot Assay result and date: ___________ ______________________
- ☐ Active TB
- ☐ Unknown
- ☐ Past positive TB infection, course taken: ________________ ______________________

Prescription

☐ **Fabrazyme (agalsidase beta)** 1 mg/kg infused every 2 weeks or ______________________________.

(A combination of 35 mg and 5 mg vials will be used that result in a dose equal to or slightly greater than the dose.

- Infuse in appropriate volume of 0.9% NS based on the patient's weight or ____________ mLs.
- Initial IV infusion rate will be 0.25 mg/min (15 mg/hr.). The infusion rate may be slowed in the event of infusion reactions.
- After patient tolerance to the infusion is well established, the infusion rate may be increased in increments of 0.05 to 0.08 mg/min (increments of 3 to 5 mg/hr.) with each subsequent infusion to a duration of not less than 1.5 hours.
- For patients weighing < 30 kg, the maximum infusion rate should remain at 0.25 mg/min (15 mg/hr.)

Refills x ________

☐ **Elfabrio (pegunigalsidase alfa-iwxj)** 1 mg/kg administered IV using filtered tubing every 2 weeks

- Dose will be rounded up to the next vial size
- Infusion rate and total volume varies by actual body weight. See product labeling.

☐ Naïve to Therapy OR ☐ Enzyme Therapy Experienced

Ancillary Orders

Anaphylaxis Kit

Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg – 25mg max) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Medication Orders

- ☐ Acetaminophen 650 mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for fever or mild discomfort. Patient may use own supply or patient may decline.
- ☐ Diphenhydramine 25 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions. Patient may use own supply or patient may decline.
- ☐ Methylprednisolone sodium succinate 40 mg IV push 20 minutes prior to infusion.
- ☐ Other: ____

IV Flush Orders

- ☐ Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.
- ☐ Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr. if accessed or weekly to monthly if not accessed.

Lab Orders

- ☐ No labs ordered at this time.
- ☐ Other: ____

Skilled nurse to administer doses intravenously in the home or alternate care setting. Refill above ancillary orders as directed x 1 year. If infusing via Peripheral IV, skilled nurse to insert.

If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: **Date:**

Prescriber Information

Prescriber Name:		**Phone:**	**Fax:**
Address:		**NPI:**	
City, State:	**Zip:**	**Office Contact:**	

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. **IMPORTANT WARNING**: This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners.

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