

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 _____					
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 ☐ <u>Peripheral:</u> 0.9% Sodium Chloride 3 to 5 mL pre-/post-use. ☐ <u>Implanted Port:</u> 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>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>					
Prescriber Signature:				Date:	
Prescriber Information					
Prescriber Name:			Phone:		Fax:
Address:			NPI:		
City, State:		Zip:		Office Contact:	
Fax completed form, insurance information, and clinical documentation to: 713-983-4647					
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