Phone: 833-394-0600 Fax: 833-996-4888

Fabrazyme IV Infusion

*Please fax a copy of patient's Demographics, Insurance Information, H&P, Diagnostic lab report (**genetic testing results**), Current Medications and Recent Visit Notes*

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: ____ **DOB**: _____/_____/_____

Allergies: __________________________ **Patient Weight:** ________lbs / kg **Height:**________

ICD-10 : ______________________, ________________________, ________________________

*******Attach genetic testing results*******

Is patient enrolled in the Genzyme Fabry registry? ☐Yes ☐ No

Fabry LABS to be drawn: ☐ Lyso GL3 ☐ IgG antibody level ☐ Prior to the first infusion, then every 3 months for the first 18 months of treatment, then every 6 months thereafter

Labs to be collected: ☐BMP ☐CMP ☐CBC w/o diff ☐CBC w/diff ☐ Other:__________

Lab Frequency: ☐ EVERY 3 months ☐ EVERY 6 months ☐ Other:________________

Pre-Medications:

Diphenhydramine PO or IV	25mg or 50mg	☐Yes	☐ No
Cetirizine PO	10mg	☐Yes	☐ No
Acetaminophen PO	650mg	☐Yes	☐ No

Fabrazyme (agalsidase beta) IV

Dose: 1mg/kg

Frequency: q2weeks

Printed Provider Name:____**Date**:______/_____/_____

Provider Signature: ____

Office Phone Number:______________________**Office Fax Number:** ________________________________

New referring providers, how did you hear about us? ☐Web Search ☐Pharma Rep ☐ Drug Locator ☐Patient ☐Word of Mouth ☐IA Clinical Liaison ☐IA Website ☐Facebook ☐Instagram ☐ Other: ______________