Fountains Infusion Center

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FABRAZYME (AGALSIDASE BETA) INFUSION ORDERS

****REQUIRED INFORMATION****

- ☐ This signed order form from the provider
- ☐ Patient demographics & insurance information
- ☐ **Clinical/Progress Notes** supporting primary diagnosis

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis:

☐ Fabry Disease (ICD-10: _____)

FABRAZYME ORDERS

☐ 1 mg/kg IV every 2 weeks

Pt. Weight _____ kg

Premedications: ☐ Tylenol 1000 mg PO

☐ Benadryl 25 mg PO

☐ Solumedrol _____mg

☐ Other: _____

****Once we receive all necessary documentation, we will schedule the patient's treatment.**

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	