Patient Name:_____

DOB:_____ Wt(kg):_____

Allergies:_____ Phone:_____

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:**	