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: _____)

Patient Weight: _____ kg

Fabrazyme Order:

- ☐ **Fabrazyme** 1mg/kg IV every 2 weeks

Premedications:

- ☐ Tylenol 1000 mg PO
- ☐ Benadryl 25 mg PO
- ☐ Solumedrol _____mg
- ☐ Other: _____

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**

Physician Signature:	**Date:**