Agalsidase beta (Fabrazyme)

Provider Order Form rev. 01/02/2024

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Fabry Disease:

Other: Description:

THERAPY ADMINISTRATION

☑ Administer Fabrazyme 1mg/kg _____ IV every 2 weeks in normal saline *(see dosing table below)*

- Initial intravenous infusion rate is 0.25mg/min (15mg/hour). Slow infusion rate in event of infusion-associated reactions
- Minimum infusion duration is 1.5hours *(based on individual patient tolerability)*
- For patient weighing 30kg or greater: after patient tolerance to infusion is well established, increase infusion rate in increments of 0.05-0.08mg/min *(increments of 3-5mg/hour)* with each subsequent infusion
- For patient weighing less than 30kg: maximum infusion rate is 0.25mg/minute *(15mg/hour)*

DOSING REFERENCE

Patient Weight Range (kg)	Total Infusion Volume (mL)
Less than or equal to 35kg	50ml
35.1 to 70kg	100ml
70.1 to 100kg	250ml
Greater than 100kg	500ml

Rechallenge: Patients who have had positive skin test to Fabrazyme or who have tested positive for antiFabrazyme IgE may be successfully rechallenged with Fabrazyme. The initial rechallenge administration should be low dose at lower infusion rate (e.g. one-half therapeutic dose (0.5 mg/kg) at 1/25th of the initial) standard recommended rate (0.01 mg/min). Once patient tolerates infusion, dose may be increased to reach approved dose of 1 mg/kg and infusion rate may be increased by slowly titrating upwards (doubled every 30 minutes up to a maximum rate of 0.25 mg/minute), as tolerated.

PRE-MEDICATION ORDERS

☑ Tylenol 650mg PO ***(required)***
☐ Loratadine 10mg PO
☐ Pepcid 20mg ☐ PO / ☐ IVP
☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP
☐ Solumedrol ☐ 40mg / ☐ 125mg IVP
☐ Other: _____

NURSING

☑ Hold infusion and notify provider for previous adverse reaction to enzyme product
☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

ADDITIONAL ORDERS

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.