

1 PATIENT INFORMATION Patient Name: _____ Phone: _____ Address: _____ City: _____ State: _____ Zip: _____ MRN #: _____ DOB: _____ Drug Allergies: _____	2 PRESCRIBER INFORMATION Prescriber's Name: _____ DEA#: _____ NPI: _____ Clinic/Facility Name: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____
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3 Instructions to Provider
 All orders with will be placed unless otherwise noted. Please fax completed order form to 206-326-2139. For drug prior authorization, call 1-888-767-4670 or visit <https://wa-provider.kaiserpermanente.org/provider-manual/clinical-review/preservice>.

4 CLINICAL INFORMATION
 Diagnosis (ICD-10 code): _____ Date of Last Dose: _____

5 FABRAZYME PRESCRIPTION INFORMATION
 First Dose: No Yes Weight: _____ kg Date Recorded: _____
Agalsidase Beta (FABRAZYME) IV infusion in 0.9% Normal Saline, to make total volume based upon patient weight in chart below

Patient weight (kg)	Minimum Total Volume (mL)
≤ 35	50
35.1 - 70	100
70.1 - 100	250
> 100	500

 Dose: _____ mg (will be rounded the nearest 5 mg) = 1 mg/kg x weight (kg)
 Route: Intravenous Frequency: Every 2 weeks Infusion Access: PIV CVAD Other: _____
 Refills: 11 months Other _____
 Patient's Current Home Care/Specialty Pharmacy: _____
Infusion Reaction Medications & Supplies

<input checked="" type="checkbox"/> Hydrocortisone sodium succinate injectable 100 mg IV Sig: Once PRN for hypersensitivity <input checked="" type="checkbox"/> Epinephrine Auto-Injector <input type="checkbox"/> 0.15mg <input type="checkbox"/> 0.3mg QTY: 2 Sig: Inject into lateral thigh muscle for severe allergic reaction. Seek medical attention after use. <input checked="" type="checkbox"/> Sodium Chloride 0.9% IV Flush: Flush 10 ml IV before/after medication administration or as needed for line maintenance	<input checked="" type="checkbox"/> Diphenhydramine injectable 25 mg IV Sig: Once PRN, may repeat x1 for urticaria, pruritis, shortness of breath <input checked="" type="checkbox"/> Sodium Chloride 0.9% IV 250ml Bag Sig: Once PRN for anaphylaxis
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 Labs /Special Instructions/Pre-Meds: _____

Infusion Protocol: <ul style="list-style-type: none"> • Infuse per manufacturer guidelines • Monitor vital signs (Temp, BP, HR, RR) every 15 minutes x 4; then every 30 minutes x2; then every 60 minutes until completion of infusion • Documentation must include: <ul style="list-style-type: none"> ○ Start and end time of infusion ○ All rate changes, vital signs, including initial and final set ○ Patient response 	<ul style="list-style-type: none"> • Observe patient for signs of infusion rate-related adverse reactions: <ul style="list-style-type: none"> ○ Blood pressure changes, increased pulse rate ○ Fever, chills ○ Headache ○ Chest, back or hip pain ○ Dyspnea ○ Mild erythema
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6 PHYSICIAN SIGNATURE REQUIRED	
X _____ (Date)	X _____ (Date)
SUBSTITUTION PERMITTED	DISPENSE AS WRITTEN