Sarah Bush Lincoln

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.

PATIENT INFORMATION

Name: | DOB:

Allergies: | Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Fabry Disease — ICD 10 Code: E75.21

☐ Other _____ — ICD 10 Code: _____

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

- ☐ This signed order form by the provider
- ☐ Patient demographics AND insurance information
- ☐ Current Medication List
- ☐ Labs and tests supporting primary diagnosis
- ☐ Clinical/Progress notes supporting primary diagnosis (must be within 1 yr)

*Patient may be required to submit a pregnancy test prior to treatment

- ☐ Confirmation of Fabry Disease
  - ☐ Molecular genetic testing
  - ☐ Enzyme assay demonstrating an absence or deficiency of normal alpha-galactosidase
- ☐ Documentation of presence of clinical signs and symptoms of Fabry Disease

List Tried & Failed Therapies, including duration of treatment:

1) _____

2) _____

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt (in kg): BMI:

Dosing

- ☐ J0180 Fabrazyme 1mg/kg IV every 2 weeks x 1 year
- ☐ Other: _____ mg IV every 2 weeks

Duration ☐ **X 6 months** ☐ **X 1 year** ☐ _____ **doses**

PREMEDICATIONS

- ☐ Tylenol _____ mg PO
- ☐ Benadryl _____ mg PO or IV
- ☐ Solumedrol _____ mg IV
- ☐ Other: _____

ADDITIONAL ORDERS / INFORMATION

Lab Orders to be drawn at time of infusion: _____ Lab Frequency: ☐ Monthly ☐ Other: _____

PRESCRIBER INFORMATION

Prescriber name :

Office Phone: | Office Fax: | Office Email:

Prescriber Signature: | Date: Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr. Suite 204 Mattoon, IL 61938
Ph. 217-258-4150 Fax 217-348-2579

☐ EFFINGHAM
901 Medical Park Dr. Suite 201 Effingham, IL 62401
Ph. 217-342-7500 Fax 217-342-7499

INFUSION ORDERS - FABRAZYME (agalsidase beta)

Clinics Scan to: Physician Orders