REVITALIZE
INFUSION CENTER

Fabrazyme®

Infusion Order Form

Patient Information:

_____ _____ _____

Patient Name **DOB** **Phone Number**

Medical Information:

Primary Diagnosis:

☐ Fabry Disease ICD-10 Code: E75.21

☐ Other_____ ICD-10 Code: _____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Medication List
- Relevant labs and tests
- Required Information:
  - Serum IgG level and GL-3 level

Height: _____

Weight: _____

Fabrazyme (agalsidase beta) Orders:

☐ Administer 1 mg/kg Fabrazyme (_____ mg) IV every two weeks for 12 months

Pre-Medication Orders:

☐ Acetaminophen 650 mg PO ☐ Diphenhydramine 50 mg PO

☐ Methylprednisolone 125 mg IV

☐ Other: _____

Lab Orders:

☐ Serum IgG Antibodies at baseline and every _____

☐ GL-3 Levels at baseline and every _____

☐ Other:_____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____ _____

Prescriber's Signature **Date**

_____ _____

Prescriber's Printed Name **Contact Phone #:**

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize Revitalize Locations InfusionPlus