FABRAZYME (AGALIDASE BETA)
Order Form

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

☐ **Demographics Attached**

Patient Name: _____ **DOB:** _____ **Phone:** _____

INSURANCE INFORMATION: Please attach a copy of insurance cards (front and back).

Medical Information

Diagnosis: ☐ Fabry disease ICD-10 Code: _____

Patient weight: _____ lbs.

Allergies: _____

☐ Clinical/progress notes, labs and tests supporting primary diagnosis attached

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

Fabrazyme Orders

Fabrazyme

☐ 1 mg/kg IV every 2 weeks

☐ Other: _____ mg every 2 weeks

Premedications:

☐ Tylenol 1000 mg PO

☐ Benadryl 25 mg PO

☐ Solumedrol _____ mg

☐ Other: _____

Additional Orders/Comments:

Physician Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Provider Name: _____ **Signature:** _____ **Date:** _____

Provider NPI: _____ **Phone:** _____ **Fax:** _____ **Contact Person:** _____

Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX

☐ Phoenix, AZ ☐ Other _____

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