



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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