

FABRAZYME® (agalsidase beta) Referral Form



Patient Preferred Clinic (select one):

PATIENT INFORMATION

Referral Status:

New Referral

Updated Order

Order Renewal

DOB:	Patient Name:	Patient Phone:	
Patient Address:	Patient Email:		
NKDA Allergies:	Weight (lbs/kg):	Height:	
ICD-10 code (required):	ICD-10 description:	Last Treatment Date:	Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

NURSING

Infusion to be administered per Vivo protocols.

FABRAZYME THERAPY ADMINISTRATION

1 mg/kg every two weeks

LABORATORY ORDERS

CBC At each dose Every _____
CMP At each dose Every _____
CRP At each dose Every _____
OTHER

REQUIRED DOCUMENTATION

PREMEDICATIONS

acetaminophen (Tylenol) 500 mg 650 mg 1000 mg PO
cetirizine (Zyrtec) 10mg PO
loratadine (Claritin) 10mg PO
diphenhydramine (Benadryl) 25 mg 50 mg PO IV
methylprednisolone (Solu-Medrol) 40mg 125mg IV
hydrocortisone (Solu-Cortef) 100mg IV
Other: _____
Dose: _____ Route: _____

Patient Demographics

Insurance Card/Information

Progress Notes Supporting DX

Current Medication List and H&P

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Provider Name (Print)

Provider Signature

Date

Fax Numbers

Virginia: 804-500-5941	Nevada: 702-489-5744	Massachusetts: 800-540-1852
Colorado: 303-418-4679	New Jersey: 609-955-3711	Pennsylvania: 215-399-9244
Florida: 904-930-4211	Ohio: 216-400-0674	New York: 800-540-1852
Texas: 469-340-0044	Oklahoma: 918-770-4421	Connecticut: 203-724-4838

Have a Question? (720) 902-4111
Email Referrals To: referrals@vivoinfusion.com
Email Specialty Referrals to: info@specialtyinfusion.com

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