

Fabrazyme® (agalsidase beta) Referral Form



Preferred Clinic (select one):

PATIENT INFORMATION

Referral Status: New Referral Updated Referral Referral 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 Digits SSN:

PROVIDER INFORMATION

Referral Coordinator Name:		Referral Coordinator Email:	
Ordering Provider:		Provider NPI:	
Referring Practice Name:		Phone:	Fax:
Practice Address:		City:	State: Zip Code:
Physician Preferred Method of Contact:	Email:	Fax:	Phone:

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
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Email Referrals To: referrals@vivoinfusion.com OR Fax Below		Have a Question? Call (720) 902-4111	
Colorado: 303-418-4679	Michigan: 833-957-2188	New York: 800-540-1852	Texas: 469-340-0044
Connecticut: 203-724-4838	Minnesota: 763-290-0903	Ohio: 216-400-0674	Virginia: 804-500-5941
Florida: 904-930-4211	Nevada: 702-489-5744	Oklahoma: 918-770-4421	Wisconsin: 414-600-5383
Massachusetts: 781-202-1629	New Jersey: 609-955-3711	Pennsylvania: 215-399-9244	