

# ELFABRIO

(pegunigalsidase alfa-iwxj)



## PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

## REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List

## PRIMARY DIAGNOSIS

- E75.21 - Fabry Disease
- Other: \_\_\_\_\_

## LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: \_\_\_\_\_

## PRE-MEDICATIONS

- Per infusion clinic protocol: No recommended standard pre-meds for Elfabrio
- Provider Prescribed: \_\_\_\_\_

## PRIMARY MEDICATION ORDER

- Elfabrio 1mg/kg IV every 2 weeks
  - Other: \_\_\_\_\_
- First Dose:  Y  N  Refill x12 months unless otherwise noted: \_\_\_\_\_

## LINE USE/CARE ORDERS

- Start PIV/ACCESS CVC  Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
- Other Flush Orders: Please fax other line care orders if checking this box

## ADVERSE REACTION & ANAPHYLAXIS ORDERS

- Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
- Other: Please fax other reaction orders if checking this box

## PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature

Date

FAX: (888) 219-8102 | EMAIL: [orders@flexcareinfusion.com](mailto:orders@flexcareinfusion.com) | VISIT: [flexcareinfusion.com/referrals](http://flexcareinfusion.com/referrals)