

# 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](http://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](http://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