ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

Fax all infusions to: 833-380-8800

Please mark the appropriate infusion center:

❑ Allenmore Infusion Center
❑ Auburn Infusion Center
❑ Gig Harbor Infusion Services
❑ Puyallup Infusion Center
❑ DHEC Infusion Center
❑ North Spokane Infusion Center
❑ North Star Lodge Infusion Center

ORDERS WITH CHECK BOXES When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Agalsidase Beta (Fabrazyme)

Patient Name:_____ Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ ❑ May leave message

Diagnosis: ❑ Fabry Disease

❑ Other_____

ICD -10 Code:

❑ _____

❑ _____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs

If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

☑ **IV Access:** Access and/or maintain IV site in accordance with MHS IV Therapy P&P: Peripheral IV Device Site Selection, Insertion, Maintenance, and Discontinuation; and Maintenance of Central Venous Catheters-Flushing, Dressing Changes and Removal.

Patient weight _____ lb/kg (required)

Treatment Regimen:

☑ Pre-meds given prior to infusion:

- Acetaminophen 650 mg po x 1 dose

Agalsidase Beta (Fabrazyme): Administered IV in NS with 0.22 micron filter

Patient wgt </= 35 kg = 50 ml TV; 35.1-70 kg = 100 ml; 70.1-100 kg = 250 ml TV; 100 mg = 500 m TV

❑ 1 mg/kg = _____mg IV every 2 weeks x _____ months (up to 12 months)

Infusion Rate: For patients >/= 30 kg: Infusion should be initiated at a rate of 15 mg/hour; after tolerance to initial infusion rate is established, the infusion rate may be increased in incements of 3 to 5 mg/hour with each subsequent infusions. Administration duration: ≥ 1.5 hours (based upon individual tolerability).

☑ **Vital Signs:** Check vital signs prior to and at completion of infusion.
Contact provider if systolic BP >180; diastolic BP >100; systolic BP <90; HR >110; temp >38C (100.4F)

If hypersensitivity develops (fever, chills, hypotension, rigors, itching, rash, etc.):

- Consult MultiCare hypersensitivity guideline for treatment management
- Notify provider of reaction, assessment and need for futher orders

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: ❑ Yes ❑ No (if yes, please send DOCUMENTATION of consent with order)

Provider Signature	Print Name	Date	Time

Another brand of drug, identical in form and content, may be dispensed unless checked ❑

Orders expire in 12 months**

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order

AGALSIDASE BETA (Fabrazyme)

MultiCare

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