

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.

Pegunigalsidase alfa-iwxj (Elfabrio®)

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

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

Diagnosis: Fabry Disease ICD -10 Code: _____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs and documentation
If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

Baseline Labs Required:

CBC Date: _____ Results: _____

Maintenance Labs:

- CMP
 Urine Protein

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.

Pre Meds:

- Dexamethasone 8 mg IVP x 1 dose • Acetaminophen 650 mg PO x 1 dose • Loratadine 10 mg PO x 1 dose

Treatment Regimen:

- Pegunigalsidase alfa-iwxj 1 mg/kg IV (based on actual body weight) Wgt = _____ (kg)
 <70 kg NS 150 ml at 50 mL/hr through in-line filter 70-100 kg NS 250 ml at 83 mL/hr through in-line filter
 >100 kg NS 500 ml at 167 mL/hr through in-line filter

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 reaction (fever, chills, hypotension, rigors, itching, rash, etc.)

- Consult MultiCare hypersensitivity guideline for treatment management
• Notify provider of reaction, assessment and need for further 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 expires in 12 months**

Patient Identification - Always Attach Patient Label

Name:
MRN #:
CSN #:
Age / Sex and Gender:

Pre-printed Order

FABRY DISEASE

MultiCare



60-0372-5 (10/25)