Orsini
Rare Disease Pharmacy Solutions

Fax To: 877-220-7581 Phone: 800-240-9572

FABRAZYME® INFUSION ORDER

(agalsidase beta)

1 PATIENT INFORMATION

Patient Name: _____ DOB: _____
Primary Phone: _____
Alternate Phone: _____
DOB: _____ Gender: ○ Male ○ Female
Allergy:
Patient Weight: _____Lbs _____Kg Date Weighed: _____
ICD-10 Diagnosis: *Fabry Disease ICD10: E75.21*

2 PRESCRIBER INFORMATION

Prescriber's Name: _____
NPI #: _____
Contact Person: _____
Phone: _____ Fax: _____
Address: _____
City, State, Zip: _____

Prescriber please review all numbered sections before signing

3 CATHETER ACCESS AND FLUSH PROTOCOL

ACCESS TYPE	CATHETER FLUSH ORDERS	PORT OCCLUSION
○ Peripheral ○ PORT *(Also include Peripheral IV PRN for Port Malfunction)*	☒ **0.9% Saline Flush:** **Dispense:** 28 Days **Refill:** x 1 Yr ____ Flush line/port with 10mL for patency/SASH protocol. **Heparin Flush:** **Dispense:** 28 Days **Refill:** x 1 Yr ____ Patients < 20kg: Flush port with 3-5mL of Heparin 10units/mL per SASH protocol Patients > 20kg: Flush port with 3-5mL of Heparin 100units/mL per SASH protocol Alternative Heparin Order: _____	**CathFlo:** 2 mg/2 mL as directed. *Pharmacy authorized to dispense upon home health nurse validated port occlusion.* **Dispense:** 1 Kit **Refill:** x 1 Yr

4 PRE-MEDICATION

Premedication for administration 30-60 min. prior to drug infusion:

☐ Antipyretic: _____ Qty 6 month **Refill:** PRN x 1 Yr
☐ Anthistamine: _____ Qty 6 month **Refill:** PRN x 1 Yr ☐ **No Premedication Needed**
☐ (EMLA) Lidocain e 2.5%/Prilocaine 2.5% or LMX4 cream - Apply 1-2 hours before port access **QTY:** 30 Gram **Refill**: PRN x 1 Yr
☐ Other Premedications: _____

5 TREATMENT REGIMEN

Fabrazyme® _____ mg IV every other week **Disp:** 28 day supply **Refill:** PRN x 1 Yr
Dose 1mg/kg - (Supplied as 5mg/1mL and 35mg/7mL) reconstituted vials
Pharmacist authorized to dispense vial combination closest/equal to prescribed dose

Infusion Volume: Please select the final Infusion volume below: (Reconstituted Fabrazyme q.s. with 0.9% saline)

Minimum Total Volume: ○ 50mL ○ 100mL ○ 250mL ○ 500mL ○ Other: _____

Infusion Rate: Specify rate scheme (manufacturer recommended initial rate 0.25mg/min (15mg/hr): _____

Post Infusion: Flush IV with 20mL 0.9% saline from 100mL 0.9% saline bag at final rate of drug infusion

Vital Signs: At baseline, hourly and completion of post infusion flush. **Other:** _____

☒ **Supplies:** Provide infusion pump, IV pole, back-up peripheral IV kit and all necessary administration supplies

ALSO SEE PAGE 2 (FABRAZYME INFUSION REACTION MANAGEMENT ORDERS)

6 PROVIDER SIGNATURE ("FABRAZYME INFUSION ORDER")

X _____
Product Substitution Permitted Signature Date of Signature

X _____
Dispense as Written Signature Date of Signature

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FABRAZYME® INFUSION REACTION MANAGEMENT ORDERS

Patient Name: _____ DOB: _____

7 EMERGENCY MEDICATIONS - #Q.S. REFILL X 1 YR ____

☒ 0.9% Saline 250mL – administer at 50mL/hr once infusion stops OR
☐ 0.9% Saline ____mL – administer at _____ml/hr once infusion stops

☐ **For mild infusion reactions**, give:
Acetaminophen 500mg po or alternate dose: _____
Diphenhydramine 25-50mg po or alternate dose: _____
☐ **For moderate infusion reactions**, give diphenhydramine 25-50mg IV
☐ **For severe infusion reactions**, give Methylprednisolone 1mg/kg IV prn
☐ **Other infusion reaction medication protocol:** _____

☒ **For severe bronchospasm/anaphylaxis, administer appropriate Epinephrine Autoinjector IM and call 911.**
Epinephrine 2-Pak 0.3mg Autoinjector IM for patients weighing ≥ than 30kg
Epinephrine 2-Pak 0.15mg Autoinjector IM for patients weighing < than 30kg

EXAMPLES OF FABRAZYME® INFUSION REACTIONS

- Bronchospasm
- Chills/Rigors
- Headache
- Rash
- Itching
- Nausea/Vomiting
- Abdominal Pain
- Irritability
- Hypotension
- Dyspnea
- Respiratory Distress

INSTRUCTIONS DURING REACTION

1) STOP FABRAZYME® and start 0.9% normal saline at 50mL/hr or at rate specified below:
☐ Other Rate: ____mL/hr

2) ADMINISTER EMERGENCY MEDS FROM BOX 7 ACCORDING TO PHYSICIAN ORDERS
☒ For severe anaphylaxis, administer appropriate Epinephrine Autoinjector IM – may repeat in 20 minutes if needed. Call 911.

3) CALL PHYSICIAN

8 PROVIDER SIGNATURE ("FABRAZYME INFUSION REACTION MANAGEMENT ORDERS")

X _____ X _____
Product Substitution Permitted Signature Date of Signature Dispense as Written Signature Date of Signature