Fabrazyme® agalsidase beta

Horizon Infusions

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to (315) 457-4305

Phone (315) 457-3091

1. PATIENT INFORMATION

Name:	**DOB:**
Phone:	**Other Phone:**
Email:	
Social Security #:	**Allergies:**
Gender: ☐ M ☐ F	**Weight:** ☐ Lbs ☐ Kg

Patient Status: ☐ New to therapy ☐ Continuing therapy ☐ Next due date *(if applicable)*:

2. INSURANCE INFORMATION (*required*)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name:		**NPI#:**
License #:	**TIN#:**	**DEA#:**
Address:		
City:		**State** **Zip**
Office Contact:		**Email:**
Office phone:		**Office fax:**

4 . DIAGNOSIS INFORMATION (ICD 10 Code *Required*)

☐ Type I Gaucher Disease (_____) ☐ Fabry Disease (_____) ☐ Psoriasis (_____) ☐ Other: _____

5. PRESCRIPTION INFORMATION (*requires new order every 12 months*)

CEREZYME
☐ Administer 60U/kg IV Q 2 weeks ***OR***
☐ Administer_____

LUMIZYME
☐ Administer 20mg/kg IV Q 2 weeks ***OR***
☐ Administer_____

FABRAZYME
☐ Administer 1mg/kg IV Q 2 weeks ***OR***
☐ Administer_____

☐ Vital signs per HI Protocol
☐ Anaphylaxis & Hydration Management per HI Protocol

PRE-MEDICATIONS ☐ N/A
☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg
☐ Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)
☐ Diphenhydrimine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV (requires driver)
☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 80mg ☐ 125mg IV
☐ Prednisone _____ mg PO
☐ Other _____

POST-MEDICATIONS ☐ N/A
☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg
☐ Prednisone _____ mg PO
☐ Other _____

6. LABS

☐ CBC w/Diff	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ CRP	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ CMP	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ ESR	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ Hepatic Panel	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ Renal Panel	☐ Each Infusion	☐ Other Frequency (*specify*): _____

☐ Quantiferon TB Gold, annually, last completed *(date)*: _____
☐ Other (*specify*):_____

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE **DATE**