



MOUNTAIN GRACE
HOME INFUSION

+1 833-360-1212 info@mginfusion.com

+1 (760) 400-6905

FABRAZYME

Date of order: _____

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Update Order ☐ Order Renewal

Date: _____ Patient Name: _____ Patient Phone: _____ DOB: _____

ICD-10 code (required): ☐ E75.21. _____

Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: info@managecaresolutions.com

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

NURSING

☒ Center will use Hypersensitivity protocol established by Mountain Grace Home Infusion and PI

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ Other _____ ☐ Frequency _____

☐ Please check this box if you DO NOT authorize Mountain Grace Home Infusion to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

THERAPY ADMINISTRATION

☒ Fabrazyme Intravenous Infusion

Dose:

☐ 1 mg/kg OR ☐ Total Dose: _____ mg

☒ Frequency: Every 2 weeks

☐ Refills: ☐ Zero/ ☐ for 12 months/ ☐ _____

(if not indicated order will expire one year from date signed)

To receive the brand-name medication, the prescribing provider must clearly write "Brand Medically Necessary" on the prescription. If this notation is absent, I4H may dispense an FDA-approved generic equivalent or biosimilar, when available.

PRE- MEDICATION ORDERS

Pre-meds not usually indicated

☐ Diphenhydramine ☐ 25mg / ☐ 50 mg ☐ PO / ☐ IV

☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650 mg PO

☐ Methylprednisolone ☐ 40mg / ☐ 125 mg IV

☐ Other: _____

Dose: _____ Route: _____ Frequency: _____

SPECIAL INSTRUCTIONS:

Provider Name (Print) : _____

Provider Signature : _____

Date : _____

Please send it to this email: info@mginfusion.com