



A Carelon Company

ELFABRIO (PEGUNIGALSIDASE ALFA) THERAPY INFUSION ORDERS

P: 877-365-5566 | **F:** 855-889-2946

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Address:		City:	State:	ZIP:
Phone:	Email:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg

Allergies:

Diagnosis Code ICD-10 (required):

Diagnosis Description:

Patient Status: New to Therapy Continuing Therapy

Next Treatment Date:

PHYSICIAN INFORMATION

Prescriber Name:		Phone:	Fax:	
Office Contact:		Email:		
Address:		City:	State:	ZIP:
NPI #:	DEA#:	Tax ID:		

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Adult Dosing	Refills
Elbafrio (pegunigalsidase alfa)	<input type="checkbox"/> 1 mg/kg IV every 2 weeks <input type="checkbox"/> Other dose: _____	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____

Pre-medication orders:

- | | | |
|--|--|--|
| <input type="checkbox"/> Acetaminophen <input type="checkbox"/> 500mg <input type="checkbox"/> 1000mg PO | <input type="checkbox"/> Normal Saline 500mL IV | <input type="checkbox"/> Cetirizine 10mg PO |
| <input type="checkbox"/> Solu-Medrol _____ mg IVP | <input type="checkbox"/> Diphenhydramine 25mg PO | <input type="checkbox"/> Cetirizine 10mg IVP |
| <input type="checkbox"/> Loratadine 10mg PO | <input type="checkbox"/> Diphenhydramine 25mg IV | <input type="checkbox"/> Other: _____ |

Other orders: _____

Lab Orders: _____ **Lab frequency:** Each infusion Other: _____

Required labs to be drawn by Paragon Healthcare Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. Dispense as written

PRESCRIBER SIGNATURE

By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Prescriber Signature: X

Date:

PATIENT INFORMATION

Name:

DOB:

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- Include signed and completed order (MD/prescriber to complete page 1)
- Include patient demographic information and insurance information
- Include patient's medication list
- Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
 - Confirmation of Fabry Disease:
 - Molecular genetic testing
 - Enzyme assay demonstrating an absence or deficiency of normal alpha-galactosidase
 - Documentation of presence of clinical signs and symptoms of Fabry Disease
- Include labs and/or test results to support diagnosis
- If patient has been on Elfabrio, please answer the following:
 - Elfabrio start date: _____
 - Has patient tolerated infusion(s)? Yes No If no, please indicate tolerability issues: _____
 - Infusion time/length of infusion: 90 minutes Other: _____
- Other medical necessity: _____