ELFABRIO (PEGUNIGALSIDASE ALFA) THERAPY INFUSION ORDERS

P: 331-236-0610 | **F:** 331-314-8989

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 331-314-8989

Name:		DOB:		Gender: □ Female □ Male	
Address:		City:	State:	ZIP:	
Phone:	Email:	Height:	□ inches □ cm	Weight:	□lbs. □ 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)	□ 1 mg/kg IV every 2 weeks □ Other dose: _____	□ x 1 year □ _____

Pre-medication orders:

□ Acetaminophen □ 500mg □ 1000mg PO
□ Solu-Medrol _____mg IVP
□ Loratadine 10mg PO
□ Normal Saline 500mL IV
□ Diphenhydramine 25mg PO
□ Diphenhydramine 25mg IV
□ Cetirizine 10mg PO
□ Cetirizine 10mg IVP
□ Other: _____

Other orders: _____

Lab Orders: _____ **Lab frequency:** □ Each infusion □ Other: _____
Required labs to be drawn by □ LIVbetter Infusions □ 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 *LIVbetter Infusions.* 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:**

COMPREHENSIVE SUPPORT FOR ELFABRIO (PEGUNIGALSIDASE ALFA) THERAPY

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
- □ Ifpatient 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: _____