



PATIENT INFORMATION

Demographics attached

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION /MEDICAL CARD(S), FRONT AND BACK

MEDICAL INFORMATION

Diagnosis: Fabry Disease ICD-10 Code: _____

Patient Weight: _____ lbs.

Allergies: _____

Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

Labs: Required labs to be drawn by: Infusion Clinic Referring Physician

Lab Orders: _____

FABRAZYME ORDERS

Fabrazyme Dose: 1mg/kg IV every 2 weeks
 Other: _____ mg every 2 weeks

Premedications: Tylenol 1000mg PO
 Benadryl 25mg PO
 Solumedrol _____ mg
 Other: _____

Additional Orders/Comments:

PHYSICIAN INFORMATION

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.

Physician Signature: _____ Date: _____

Physician Name: _____

Phone: _____ Fax: _____ Contact Person: _____

INFUSION CENTER LOCATIONS

Phone: 877-365-5566
Fax: 855-889-2946

Texas

Arlington Austin Dallas Houston North Hills
 Plano Round Rock San Antonio Stone Oak

Tennessee

Knoxville

Georgia

Atlanta