

Pegunigalsidase alfa-iwxj (Elfabrio)



Provider Order Form Revised 10/30/2025

PROVIDERS: Please include the following information to expedite the order:
Patient Demographic, most recent Office Visit Note, Insurance Information, TB Results, Recent Labs

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: _____ Patient Name: _____ DOB: _____

ICD-10 code: ☐ E75.21 ☐ Other: _____

ICD 10 Description: _____

☐ NKDA Allergies: _____ Weight (lb/kg) _____

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

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

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

NURSING

- ☒ Utilize Hypersensitivity protocol established by Redeemer Health Infusion and PI
- ☒ Provide nursing care and observation per Redeemer Health Infusion Policies and Procedures

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ CRP ☐ at each dose ☐ every _____

☐ Other: _____

☐ Please check this box if you do NOT authorize Redeemer Health Infusion to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

PRE-MEDICATION ORDERS

Not typically indicated for this medication.

☐ acetaminophen (Tylenol) ☐ 500 mg/ ☐ 650 mg/ ☐ 1000 mg PO

☐ cetirizine (Zyrtec) 10 mg PO

☐ loratadine (Claritin) 10 mg PO

☐ diphenhydramine (Benadryl) ☐ 25 mg/ ☐ 50 mg ☐ PO/☐ IV

☐ methylprednisolone (Solu-Medrol) ☐ 40 mg/ ☐ 125 mg IV

☐ hydrocortisone (Solu-Cortef) 100 mg IV

☐ Other: _____

Dose: _____ Route: _____

Frequency: _____

THERAPY ADMINISTRATION

☒ Pegunigalsidase alfa-iwxj (Elfabrio) in 0.9% sodium chloride IV solution

☐ Dose: 1 mg/kg

- **Route:** ☒ Intravenous
- **Rate:** Based on body weight per PI guidelines (minimum duration of 1.5 hours)
- **Frequency:**
 - ☐ Once every two weeks
- ☒ Use in-line low protein-binding 0.2 micron, in-line filter.
- ☒ Flush with 0.9% sodium chloride after infusion completion
- ☒ Patient is required to stay for 30-minute observation post infusion
- Refills: ☐ Zero/ ☐ for 12 months/ ☐ Other: _____
(If not indicated, order will expire one year from date signed)

To ensure a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, Redeemer Infusion is authorized to administer a generic or biosimilar.

SPECIAL INSTRUCTIONS

☐ Please check this box if you DO NOT authorize Redeemer Health Infusion to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.

Provider Name (Print)

Provider Signature

Date