ISEMBYLD™ (apitegromab-mstn) PRESCRIBER ORDER FORM

Patient Name:	**Date of Birth:**	**Gender:**
Address:		
Phone:	**Height:** _____ ☐ inches ☐ cm	**Weight:** _____ ☐ lbs ☐ kg **Date weight obtained:** _____

Clinical Information

Primary Diagnosis Description: Spinal Muscular Atrophy	**ICD-10 Code:** G12.9
Other Diagnosis Description:	**ICD-10 Code:**

Concomitant Disease Modifying Therapy ***(must be supplied by alternate pharmacy/provider)*****:** ☐ Evrysdi® ☐ Spinraza®

Allergies: ☐ NKDA OR (List):

ISEMBYLD™ (apitegromab-mstn) Prescription

ISEMBYLD™ (apitegromab-mstn) refill as directed x 1 year

☐ Infuse 10 mg/kg IV every 4 weeks over approximately 60-120 min at a rate of no greater than 150mL/hour.
Dilute in 0.9% sodium chloride to a concentration of 5 mg/mL.
Flush IV tubing with 0.9% Saline Solution 10 to 20 mL before and after each infusion.

☐ Other: _____

Ancillary Orders

Does this patient require an anaphylaxis kit?

☐ Yes, with 1st dose ☐ Yes, with all doses ☐ No

Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ or IM x 1; repeat x 1 in 5 to 15 min PRN
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg – 25mg max per dose) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Medication Orders

☐ Lidocaine/prilocaine 2.5%/2.5% (or equivalent) anesthetic cream 30 gm – apply topically 30 min prior to venipuncture or port access as needed for numbing.

☐ Other: _____

IV Flush Orders

- Peripheral: 0.9% Sodium Chloride 3 to 5 mL pre-/post-use.
- Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed. If unable to obtain implanted port access, it is acceptable to establish a peripheral IV access and administer peripherally.

Lab Orders

☐ No labs ordered at this time.

☐ Other: _____

Skilled nurse to assess and administer via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.
If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:	**Phone:**	**Fax:**
Address:	**NPI:**	
City, State: **Zip:**	**Office Contact:**	

Fax completed form, insurance information, and clinical documentation to: 410-558-6439

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Not valid for use for patients residing in Arizona, New York, and Wisconsin

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