

CASIMERSEN (AMONDYS 45®) PRESCRIBER ORDER FORM

Patient Name:

Date of Birth:

Gender:

Address:

Phone:

Height: _____ ☐ inches ☐ cmWeight: _____ ☐ lbs ☐ kg

Date weight obtained: _____

Clinical Information

Primary Diagnosis Description: Duchenne muscular dystrophy (DMD)

ICD-10 Code: G71.01

Allergies:

Casimersen (AMONDYS 45®) Prescription**Casimersen (AMONDYS 45®) refill as directed x 1 year**

Infuse 30 mg/kg IV over 35 to 60 minutes every week (+/- 3 days to allow for patient/nurse scheduling).

Dose will be rounded to closest 100 mg.

Flush IV tubing with 0.9% Sodium Chloride 10 to 20 mL after each infusion.

Prescriber will obtain weight for non-ambulatory patients and provide dose changes to pharmacy as needed. Prescriber will arrange monthly dipstick proteinuria monitoring.

Ancillary Orders**Anaphylaxis Kit**

Does this patient require an anaphylaxis kit?

☐ Yes, with 1st dose ☐ Yes, with all doses

- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ 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) 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 2 to 3 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

- ☐ Serum cystatin C and random urine protein-to-creatinine ratio, prior to infusion, every 3 months.
- ☐ 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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