ECALLANTIDE (KALBITOR®) PRESCRIBER ORDER FORM

Patient Name:	Date of Birth:	Gender:
Address:		

Phone:	Height:	☐ inches ☐ cm	Weight:	☐ lbs. ☐ kg

Clinical Information

Primary Diagnosis Description: Defects in the complement system (hereditary angioedema)	ICD-10 Code: D84.1

Ecallantide (Kalbitor®) Prescription

Ecallantide (Kalbitor®) 30 mg (3 x 10 mg/mL vials) refill as directed x 1 year

Inject a total dose of 30 mg SUBQ as 3 x 10 mg (1 mL) SUBQ injections PRN acute HAE attack.

If no response in 45 to 60 minutes after initial dose, an additional total dose of 30 mg SQ may be administered.

If no response in 45 to 60 minutes after the second dose, call the prescriber.

Dispense _____ doses.

Keep _____ doses on-hand at all times.

Ancillary Orders

Anaphylaxis Kit

- 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.

Pre-Medication Orders

☐ Other: _____

Skilled nurse to administer doses SUBQ as ordered. 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: 713-983-4647

