Dear Provider,

Specialty therapies can be complex, and complete information is essential to help ensure timely access to care.

The following prescriber order form is designed to capture the necessary clinical and patient information the dispensing pharmacy requires to begin the applicable prescribed therapy.

If your patient has elected to use Option Care Health, please fax completed form and required clinical documentation to **713-983-4647**.

Sincerely,
Option Care Health

KANUMA® Prescriber Order Form

To:	Phone:	Fax:	Date:
From:	Phone: X	Fax:	# Pages, Incl. Cover:

Patient Name:	Patient Phone:	DOB:	Gender:
Address:	City:	State:	Zip:

Primary Diagnosis

☐ E75.5, E75.6 Lysosomal acid lipase deficiency

Clinical Background and Orders

1

Ht: _____ ☐ in ☐ cm Wt: _____ ☐ lb ☐ kg Date: _____ Code Status: _____ IV Access: _____

Allergies: ☐ NKDA OR (list): _____

Please attach the following: patient demographics, insurance information, history and physical, and medication list

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KANUMA (sebelipase alfa) Prescription:

Pediatric and Adult LAL:

☐ 1 mg/kg* IV every other week x _____doses

Rapidly Progressive LAL Presenting within the First 6 Months of Life:

☐ 1 mg/kg* IV weekly x _____ doses

☐ 3 mg/kg* IV weekly x _____ doses

*round dose to next whole vial

Pharmacy to contact prescriber for dosing adjustments requiring additional vials when change in weight is consistent over at least 2 - 3 weeks; new dose will be initiated with next dose after order received

☐ Dilute dose in 0.9% sodium chloride to a final volume based on patient weight as referenced in the product labeling. Infuse IV over at least 2 hours. Consider extending infusion time for patients receiving 3 mg/kg dose, or those with history of hypersensitivity reaction. A 1 hr infusion may be considered for patients receiving the 1 mg/kg dose who tolerate the infusion. At the end of the infusion, flush administration set with an additional 10 ml 0.9% sodium chloride to deliver the residual KANUMA dose volume remaining in the administration set.

☐ Other: _____

Additional Orders:

- Premedication:
  - ☐ Acetaminophen _____ mg orally 30 minutes before infusion
  - ☐ Diphenhydramine _____ mg orally 30 minutes before infusion
  - ☐ Methylprednisolone _____ mg IV push 20 minutes prior to infusion
  - ☐ Other: _____
- Adverse Reactions:
  - Refer to the attached Treatment Guidelines and Physicians Order for Adult or Pediatric Drug Related Adverse Reactions.

☐ Other: _____

Refill ancillary medications x 1 year.

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Catheter Maintenance, Supply and Nursing Orders:

☐ LMX-4 4% Anesthetic Cream 30g (or equivalent) - apply topically prior to venipuncture or port access as needed.

- If applicable, flush intravenous access device per Option Care protocol (refer to chart at the right).
- Provide all supplies necessary to administer therapy.
- Skilled nurse to administer doses in the home/alternate care setting, start peripheral line (where required), access/maintain central IV access (where applicable), monitor and treat ADRs, and administer medications as ordered.

Access Device Flush Protocol	0.9% Sodium Chloride Flush	Heparin
Peripheral	2 - 3 ml pre/post use	May use 1 - 3 ml heparin (10 units/ml) post use or every 24 hrs
Peripheral-Midline	3 - 5 ml pre/post use; 5 ml pre/10 ml post lab draw	3 ml heparin (10 units/ml) post-use; 3 ml heparin (10u/ml)every 12 hrs (or) 3 ml heparin (100 units/ml) every 24 hrs
PICC & Central Tunneled & Non-tunneled	5 ml pre/post use; 5 ml pre/10 ml post lab draw	3 ml (heparin 100 units/ml) *or* 5 ml (10 units/ml) post use; maintenance q24hr
Implanted Port	5 - 10 ml pre/post infusion 10 - 20 ml pre/ post lab draw	3 - 5 ml (100 units/ml) post use; maintenance if accessed 3 - 5 ml q24hr or if not accessed 3 - 5 ml weekly to monthly
Valved Catheters: Chest, PICC, Midline	5 - 10 ml pre/post use; 10 - 20 ml pre/post lab draw; maintenance 5 - 10 ml at least weekly	N/A

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Lab and Other Orders:

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 Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Office Contact: _____

Direct Contact Number/Extension: _____

Local Contact Information: _____

