



option care health®

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**

2 **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.**

3 **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

4 **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: \_\_\_\_\_

**CONFIDENTIAL HEALTH INFORMATION:** Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. **IMPORTANT WARNING:** This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners.

Local Contact Information: \_\_\_\_\_