

Niktimvo™ (axatilimab-csfr) PRESCRIBER ORDER FORM

Patient Name:

Date of Birth:

Gender:

Address:

Phone:

Height:

inches cm

Weight:

lbs kg

Clinical Information

Primary Diagnosis: Chronic graft-versus-host disease (cGVHD) Other: _____ ICD-10 Code: _____

Allergies: NKDA OR (List): _____

Is this first dose? Yes – Date of first dose: _____ No – Date of last dose: _____

Niktimvo™ (axatilimab-csfr) Prescription

Niktimvo™ (axatilimab-csfr) refill as directed x 1 year

- Infuse 0.3 mg/kg (for patients weighing at least 40 kg, up to 35 mg maximum) IV over 30 minutes every 2 weeks x1 year
 Other: _____

Dispense quantity sufficient of Niktimvo™ 9mg, 22 mg, and/or 50 mg single dose vials for each dose.
Withdraw required amount from vials and discard any unused vial contents.

Ancillary Orders

Anaphylaxis Kit

If this is a 1st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?

Yes No

Dosage:

- Epinephrine 0.3mg (>30kg), 0.15mg (15 to 30kg), or 0.01 mg/kg (<15kg) SUBQ or IM x 1; repeat x1 in 5 to 15 min PRN.
- Diphenhydramine 25mg (>30kg) 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

- Acetaminophen 650 mg PO 30 min before infusion. Patient may decline.
 Famotidine 20mg PO 30 min before infusion. Patient may decline.
 Diphenhydramine 25 mg PO 30 min before infusion. Patient may decline.
 Other: _____

IV Flush Orders

- Peripheral: NS 2 to 3ml pre-/post-use
- Implanted Port: NS 5 to 10ml 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

Lab Orders

- No labs ordered at this time
 Other: _____

Skilled nurse to assess and administer where appropriate 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: 713-983-4647

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