

**POTELIGEO® (mogamulizumab-kpkc) PRESCRIBER ORDER FORM**

Patient Name:

Date of Birth:

Gender:

Address:

Phone:

Height:

 inches  cm

Weight:

 lbs.  kg**Clinical Information**

Primary Diagnosis Description:

ICD-10 Code:

Date of first dose received (Day 1):

**POTELIGEO® (mogamulizumab-kpkc) Prescription****POTELIGEO®(mogamulizumab-kpkc) Refill as directed x1 year. First dose to be administered in prescriber's office.**

1 mg/kg administered as an intravenous infusion over at least 60 minutes. Administer on days 8, 15, and 22 of the first 28-day cycle, then on days 1 and 15 of each subsequent 28-day cycle until disease progression or unacceptable toxicity. Administer within 2 days of the scheduled dose. Calculate the dose (mg/kg) and number of single dose vials needed to prepare the infusion solution based on patient weight. Whole vials will be dispensed based on calculated dose. Discard any unused portion left in the vial.

**Ancillary Orders****Anaphylaxis Orders**

- 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**

- Acetaminophen 650 mg PO 30 min before infusion.
- Diphenhydramine 25 mg PO 30 min before infusion.
- Other: \_\_\_\_\_

**IV Flush Orders**

- Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.
- PICC and Central Tunneled/Non-Tunneled: 0.9% Sodium Chloride 5 to 10 pre-/post-use, 5 mL pre-lab draw and 10 ml post-lab draw. Heparin (10 unit/mL) 5 mL or (100 unit/mL) 3 mL every 24 hr.
- 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.
- Valved Catheters: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. For maintenance, 0.9% Sodium Chloride NS 5 to 10 ml at least weekly

**Lab Orders**

- 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: 713-983-4647**

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