SARCLISA® (ISATUXIMAB-IRFC) PRESCRIBER ORDER FORM

Patient Name:	**Date of Birth:**
Address:	
Phone:	**Height:** _____ ☐ inches ☐ cm **Weight:** _____ ☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

Is this the first dose? ☐ **YES** – Date of first dose: _____ ☐ **NO** – Date of next dose due: _____

SARCLISA®(isatuximab-irfc) Prescription

Sarclisa (isatuximab-irfc) 10 mg/kg in 250 mL sodium chloride 0.9% as an intravenous infusion. Dose based on weight taken prior to each cycle.

- ☐ Cycle 1: Administer on Days 1, 8, 15, and 22 (weekly)
- ☐ Cycle 2 and beyond: Administer on Days 1, 15 (every 2 weeks)
- ☐ Other:_____

	Dilution Volume	**Initial Rate**	**No infusion reaction**	**Rate Increase by**	**Max Rate**
1st Infusion	250 mL	25 mL/hr	For 60 minutes	25 mL/hr every 30 minutes	150 mL/hr
2nd Infusion	250 mL	50 mL/hr	For 30 minutes	100 mL/hr every 30 minutes	200 mL/hr
Subsequent Infusions	250 mL	200 mL/hr	-	-	200 mL/hr

Ancillary Orders

Anaphylaxis Kit

Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ 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 – 25mg max dose) 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

- ☐ Dexamethasone 20 mg IV on the days of SARCLISA and/or carfilzomib infusions, orally on day 22 in cycle 2 and beyond, and orally on day 23 in all cycles.
- ☐ 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: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.
- ☐ 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.

Lab Orders

- ☐ No labs ordered at this time.
- ☐ Other: _____

Skilled nurse to administer doses intravenously in the alternate care setting. Refill above ancillary orders as directed x 1 year.

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:

