

SARCLISA® (ISATUXIMAB-IRFC) PRESCRIBER ORDER FORM

Patient Name:

Date of Birth:

Gender:

Address:

Phone:

Height: _____ ☐ inches ☐ cmWeight: _____ ☐ lbs ☐ kg**Clinical Information**

Primary Diagnosis Description:

ICD-10 Code:

Is this the first dose? ☐ YES – Date of first dose: _____ ☐ NO – Date of last dose: _____**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
1 st Infusion	250 mL	25 mL/hr	For 60 minutes	25 mL/hr every 30 minutes	150 mL/hr
2 nd 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) 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 – 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.**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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