


# CASIMERSEN (AMONDYS 45®) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to: **(410) 558-6439**

 option care health	<b>Patient Name:</b> _____	<b>Date of Birth:</b> _____
	<b>Address:</b> _____	
	<b>Phone:</b> _____	<b>Height:</b> _____ <input type="checkbox"/> inches <input type="checkbox"/> cm

## Clinical Information

<b>Primary Diagnosis Description:</b> Duchenne muscular dystrophy (DMD)	<b>ICD-10 Code:</b> G71.01
<b>Allergies:</b> _____	

## Casimersen (AMONDYS 45®) Prescription

### Casimersen (AMONDYS 45®) refill as directed x 1 year

Infuse 30 mg/kg IV over 35 to 60 minutes every week (+/- 3 days to allow for patient/nurse scheduling).

Dose will be rounded to closest 100 mg.

Flush IV tubing with NS 10 to 20 mL after each infusion.

Prescriber will obtain weight for non-ambulatory patients and provide dose changes to pharmacy as needed. Prescriber will arrange monthly dipstick proteinuria monitoring.

## Ancillary Orders

### Anaphylaxis Kit

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

Yes  No

- 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) IV or IM; repeat x 1 in 15 min PRN no improvement
  - Normal saline 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. Patients ≤ 30 kg, infuse over 2 to 4 hours PRN headache rated > 5 on pain scale.

### Medication Orders

Lidocaine/prilocaine 2.5%/2.5% (or equivalent) anesthetic cream 30 gm – apply topically 30 min prior to venipuncture or port access as needed for numbing.

Other: \_\_\_\_\_

### IV Flush Orders

- Peripheral: NS 2 to 3 mL pre-/post-use.
- Implanted Port: NS 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. If unable to obtain implanted port access, it is acceptable to establish a peripheral IV access and administer peripherally.

### Lab Orders

- Serum cystatin C and random urine protein-to-creatinine ratio, prior to infusion, every 3 months.
- No labs ordered at this time.
- Other: \_\_\_\_\_

Skilled nurse to assess and administer and/or teach self-administration, where appropriate, via access device as indicated above. Nurse will provide ongoing support as needed. 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

<b>Prescriber Name:</b> _____	<b>Phone:</b> _____	<b>Fax:</b> _____
<b>Address:</b> _____	<b>NPI:</b> _____	
<b>City, State:</b> _____	<b>Zip:</b> _____	<b>Office Contact:</b> _____

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