

# KANUMA® Prescriber Order Form

To:	Phone:	Fax:	Date:
From:	Phone: X	Fax:	# Pages, Incl. Cover:
Patient Name:		Patient Phone:	DOB:
Address:		City:	State: Zip:

**Primary Diagnosis**

E75.5, E75.6 Lysosomal acid lipase deficiency

**Clinical Background and Orders**

1 Ht: \_\_\_\_\_  in  cm Wt: \_\_\_\_\_  lb  kg Date: \_\_\_\_\_ Code Status: \_\_\_\_\_ IV Access: \_\_\_\_\_  
 Allergies:  NKDA OR (list): \_\_\_\_\_  
**Please attach the following: patient demographics, insurance information, history and physical, and medication list**

2 **KANUMA (sebelipase alfa) Prescription:**  
**Pediatric and Adult LAL:**  
 1 mg/kg\* IV every other week x \_\_\_\_\_ doses  
**Rapidly Progressive LAL Presenting within the First 6 Months of Life:**  
 1 mg/kg\* IV weekly x \_\_\_\_\_ doses  
 3 mg/kg\* IV weekly x \_\_\_\_\_ doses  
 \*round dose to next whole vial  
 Pharmacy to contact prescriber for dosing adjustments requiring additional vials when change in weight is consistent over at least 2 - 3 weeks; new dose will be initiated with next dose after order received  
 Dilute dose in 0.9% sodium chloride to a final volume based on patient weight as referenced in the product labeling. Infuse IV over at least 2 hours. Consider extending infusion time for patients receiving 3 mg/kg dose, or those with history of hypersensitivity reaction. A 1 hr infusion may be considered for patients receiving the 1 mg/kg dose who tolerate the infusion. At the end of the infusion, flush administration set with an additional 10 ml 0.9% sodium chloride to deliver the residual KANUMA dose volume remaining in the administration set.  
 Other: \_\_\_\_\_

**Additional Orders:**

- Premedication:
  - Acetaminophen \_\_\_\_\_ mg orally 30 minutes before infusion
  - Diphenhydramine \_\_\_\_\_ mg orally 30 minutes before infusion
  - Methylprednisolone \_\_\_\_\_ mg IV push 20 minutes prior to infusion
  - Other: \_\_\_\_\_
- Adverse Reactions:
  - Refer to the attached Treatment Guidelines and Physicians Order for Adult or Pediatric Drug Related Adverse Reactions.
  - Other: \_\_\_\_\_

**Refill ancillary medications x 1 year.**

3 **Catheter Maintenance, Supply and Nursing Orders:**

LMX-4 4% Anesthetic Cream 30g (or equivalent) - apply topically prior to venipuncture or port access as needed.

- If applicable, flush intravenous access device per Option Care protocol (refer to chart at the right).
- Provide all supplies necessary to administer therapy.
- Skilled nurse to administer doses in the home/alternate care setting, start peripheral line (where required), access/maintain central IV access (where applicable), monitor and treat ADRs, and administer medications as ordered.

Access Device Flush Protocol	0.9% Sodium Chloride Flush	Heparin
Peripheral	2 - 3 ml pre/post use	May use 1 - 3 ml heparin (10 units/ml) post use or every 24 hrs
Peripheral-Midline	3 - 5 ml pre/post use; 5 ml pre/10 ml post lab draw	3 ml heparin (10 units/ml) post-use; 3 ml heparin (10u/ml) every 12 hrs (or) 3 ml heparin (100 units/ml) every 24 hrs
PICC & Central Tunneled & Non-tunneled	5 ml pre/post use; 5 ml pre/10 ml post lab draw	3 ml (heparin 100 units/ml) or 5 ml (10 units/ml) post use; maintenance q24hr
Implanted Port	5 - 10 ml pre/post infusion 10 - 20 ml pre/post lab draw	3 - 5 ml (100 units/ml) post use; maintenance if accessed 3 - 5 ml q24hr or if not accessed 3 - 5 ml weekly to monthly
Valved Catheters: Chest, PICC, Midline	5 - 10 ml pre/post use; 10 - 20 ml pre/post lab draw; maintenance 5 - 10 ml at least weekly	N/A

4 **Lab and Other Orders:**

*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 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Office Contact: \_\_\_\_\_  
 Direct Contact Number/Extension: \_\_\_\_\_

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Local Contact Information: \_\_\_\_\_ Fax to: \_\_\_\_\_