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

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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

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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.

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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

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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: _____

Local Contact Information: _____ Fax to: _____

