Orsini Specialty Pharmacy

ADZYNMA INFUSION ORDER FORM

(ADAMTS13, recombinant-krhn)

1 PATIENT INFORMATION

Patient Name: _____ DOB: _____
Primary Phone: _____ Gender: ◯ Male ◯ Female
Address: _____
City, State, Zip: _____
Allergy: _____
Patient Weight: _____ Lbs _____ Kg Date Weighed: _____
Venous Access ◯ Peripheral IV ◯ Port ____G ____ Inch needle
Device: ☐ PIV for port access complications

2 PRESCRIBER INFORMATION

Prescriber's Name: _____
Contact Person: _____ Phone: _____
NPI #: _____
Address: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Diagnosis: ◯ *D69.42* ◯ *Other ICD-10*

3 CATHETER ACCESS AND FLUSH PROTOCOL

ACCESS TYPE	CATHETER FLUSH ORDERS	
◯ Peripheral ◯ PORT *(Also include Peripheral IV for Port Malfunction)*	☒ **0.9% Saline Flush:** **Dispense:** 30 Days **Refills:** x 1yr OR ___ Refills Flush line/port with 10mL for patency/SASH protocol. ☐ **Heparin Flush:** **Dispense:** 30 Days **Refills:** x 1yr OR ___ Refills Flush port with _____ mL of Heparin _____units/mL per SASH protocol.	**CathFlo:** 2 mg/2 mL as directed. *Pharmacy authorized to dispense upon home health nurse validated port occlusion.* ☐ **Dispense:** 1 Kit **Refills:** x 1yr OR ___ Refills

4 PRE-MEDICATION

Premedication for administration 30-60 min. prior to drug infusion:

☐ Antipyrectic: _____ q.s. 1 month **Refill:** x 1yr OR ___ Refills ☐ Not Needed
☐ Anthistamine: _____ q.s. 1 month **Refill:** x 1yr OR ___ Refills ☐ Not Needed
☐ LMX 4 or (EMLA) Lidocaine 2.5%/Prilocaine 2.5% cream - Apply topically 1 hour prior to starting IV or accessing port **QTY:** 1 **Refill**: x 1yr OR ___ Refills
☐ _____

5 TREATMENT REGIMEN

DOSE (PROPHYLAXIS)	PRESCRIPTION
☐ Adzynma 40 IU/kg	Infuse Adzynma _____ units (± 10%) via IV push every _____ week(s) at a rate of 2 - 4ml per minute **Quantity:** Pharmacy to dispense quantity of vials sufficient for prescribed dose (± 10%). Dose and volume calculated based on patient's body weight using actual vial contents potency as printed on vial label, not the nominal potency i.e. 1500IU/500IU. **Dispense:** 28 day supply **Refills:** 12 months *(Patients experiencing an acute event should be referred to a hospital setting for assessment and potential need for on-demand treatment)*

SKILLED NURSING VISIT

☐ As needed for IV access, administration, and proper clinical monitoring | Administration procedures to be followed per pharmacy protocol

Post Infusion: Flush IV with 10 mL 0.9% Sodium Chloride Injection, USP at final rate of drug infusion
Vital Signs: At baseline, and at every ____ minutes during infusion, at completion of post infusion flush and 30 minutes after completion of post infusion flush

☒ **Supplies:** Provide infusion pump if needed, back-up peripheral IV kit and all necessary infusion supplies.

ALSO SEE PAGE 2 ("ADZYNMA INFUSION REACTION MANAGEMENT ORDERS)

6 PROVIDER SIGNATURE

X _____
Product Substitution Permitted Signature Date of Signature

X _____
Dispense as Written Signature Date of Signature

Orsini Specialty Pharmacy

INFUSION REACTION MANAGEMENT ORDERS

Patient Name: _____ DOB: _____

7 EMERGENCY MEDICATIONS - #q.s. Refill: x 1yr OR___ Refills

- ☐ Diphenhydramine 50 mg/mL _____ mg IV if Infusion Reaction
- ◯ Epinephrine 2-Pak 0.3 mg injector IM once for severe brochospasm/anaphylaxis and call 911 (for patients weighing ≥ 30kg)
- ◯ Epinephrine 2-Pak 0.15 mg injector - IM once for severe brochospasm/anaphylaxis and call 911 (for patients weighing < 30kg)
- ☐ Corticosteroid: _____
- ☐ 0.9% Saline 250 mL - administer at 50 mL/hr once Adzynma infusion stops:
- ☐ 0.9% Saline _____ mL - administer at _____ mL/hr once Adzynma infusion stops:
- ☐ **Supplies:** Provide infusion pump if needed, back-up peripheral IV kit and all necessary infusion supplies.

EXAMPLES OF COMPLEX THERAPY INFUSION REACTIONS

- Fever
- Chills/Rigors
- Headache
- Rash/Itching
- Swelling/Edema
- Nausea/Vomiting
- Abdominal Pain
- Irritability
- Hypotension
- Dyspnea
- Respiratory Distress

INSTRUCTIONS DURING REACTION

1) STOP ADZYNMA and start 0.9% normal saline at 50 mL/hr.

☒ Other Rate: _____ mL/hr

2) ADMINISTER EMERGENCY MEDS FROM BOX 7 ACCORDING TO PHYSICAN ORDERS

☒ For severe anaphylaxis, administer appropriate Epinephrine Autoinjector IM - may repeat in 20 minutes if needed. Call 911.

3) CALL PHYSICIAN

8 PROVIDER SIGNATURE ("Adzynma Infusion Reaction Management Orders")

X _____ Product Substitution Permitted Signature _____ Date of Signature

X _____ Dispense as Written Signature _____ Date of Signature