

AVLAYAH™ INFUSION ORDER

(tividenofusp alfa-eknm)

1 PATIENT INFORMATION

Patient Name: _____ DOB: _____
 Primary Phone: _____ Gender: Male Female
 Alternate Contact Name: _____
 Address: _____ Phone: _____
 City, State, Zip: _____
 Allergy: _____
 Patient Weight: _____ Lbs _____ Kg Date Weighed: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____
 Contact Person: _____ Phone: _____
 NPI #: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____ Fax: _____
 ICD-10 Diagnosis: *E76.1 Hunter Syndrome*

3 CATHETER ACCESS AND FLUSH PROTOCOL

ACCESS TYPE	CATHETER FLUSH ORDERS	
Peripheral PORT (Also include Peripheral IV for Port Malfunction)	<input checked="" type="checkbox"/> 0.9% Saline Flush: Dispense: 28 Days Refills: x 1 Yr OR ____ Refills Flush line/port with 10mL for patency/SASH protocol. Heparin Flush: Dispense: 28 Days Refills: x 1 Yr OR ____ Refills Patients < 20kg: Flush port with 3-5mL of Heparin 10units/mL per SASH protocol Patients ≥ 20kg: Flush port with 3-5mL of Heparin 100units/mL per SASH protocol Alternative Heparin Order: _____	CathFlo: 2 mg/2 mL as directed. <i>Pharmacy authorized to dispense upon home health nurse validated port occlusion.</i> Dispense: 1 Kit Refills: x 1 Yr OR ____ Refills

4 PRE-MEDICATION

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

- Antipyretic: _____ q.s. 28 days **Refill:** x 1 Yr OR ____ Refills
 Antihistamine: _____ q.s. 28 days **Refill:** x 1 Yr OR ____ Refills **No Premedication Needed**
 Corticosteroid: _____ q.s. 28 days **Refill:** x 1 Yr OR ____ Refills
 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
 Other Premedications: _____

5 TREATMENT REGIMEN

AVLAYAH DOSE	PRESCRIPTION
<input type="checkbox"/> 3 mg/kg once weekly <input type="checkbox"/> 7.5 mg/kg once weekly <input type="checkbox"/> 15 mg/kg once weekly	Infuse calculated dose of AVLAYAH IV once weekly. Disp: 28 days Refills: 12 months <i>Pharmacy to calculate dose and dispense appropriate number of vials for infusion rounding up to the next whole vial. (Each vial of AVLAYAH yields 150mg/5mL upon reconstitution with 5.2mL of Sterile Water for Injection.)</i>

PREPARATION AND ADMINISTRATION

Reconstitute each required AVLAYAH vial with 5.2mL of Sterile Water for Injection to yield 150mg/5mL of drug solution per vial
Dilute reconstituted AVLAYAH dose in appropriate volume of 0.9% Sodium Chloride to reach the Total Infusion Volume below. *Final concentration between 0.6mg/mL and 15mg/mL*
Total Infusion Volume: 25mL 50mL 100mL 250mL Other: _____ mL
Infusion Rate: Infuse at rate schedule indicated in the manufacturer package insert based upon total infusion volume.
Infusion Rate Schedule
 Step 1: _____ mL/hr for _____ min if tolerated increase to
 Step 2: _____ mL/hr for _____ min if tolerated increase to
 Step 3: _____ mL/hr final rate for remainder of infusion duration
 Other Rate Directions: _____

Infuse diluted AVLAYAH solution through in-line low protein-binding 0.2µ filter at rate schedule specified above

Post Infusion: Flush IV with 15 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

SKILLED NURSING VISIT

- As needed for IV access, administration, and proper clinical monitoring Administration procedures to be followed per pharmacy protocol
 Supplies: Provide infusion pump if needed, IV pole, back-up peripheral IV kit and all necessary infusion supplies including Sterile Water for Injection

6 LAB ORDERS

- Protein and Creatinine Random Urine to measure UPCR every 3 months or _____
 Cystatin C every 3 months or _____
 Hemoglobin every 3 months or _____ Other Labs: _____

ALSO SEE PAGE 2 (AVLAYAH INFUSION REACTION MANAGEMENT ORDERS)

7 PROVIDER SIGNATURE ("AVLAYAH Infusion Order")

Product Substitution Permitted Signature _____ Date of Signature _____
 Dispense as Written Signature _____ Date of Signature _____

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