

AMONDYS 45™ INFUSION ORDER

(casimersen)

1 PATIENT INFORMATION

Patient Name: _____
 Primary Phone: _____ DOB: _____
 Allergy: _____
 Gender: ☐ Male ☐ Female
 Patient Weight: _____ Lbs _____ Kg Date Weighed: _____
 Diagnosis: G71.01 Duchenne/Becker Muscular Dystrophy

2 PRESCRIBER INFORMATION

Prescriber's Name: _____
 State License #: _____ NPI #: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____ Fax: _____
 Contact Person: _____ Phone: _____

3 CATHETER ACCESS AND FLUSH PROTOCOL

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

4 TREATMENT REGIMEN

Administer pre-medication 30-60 min prior to drug infusion

PRE-MEDICATION		CATHETER FLUSH ORDERS	
☐ Antipyretic: _____	Qty: 6 month Refills: PRN x 1yr	☐ Antihistamine: _____	Qty: 6 month Refills: PRN x 1yr
☐ EMLA (Lidocaine 2.5%/Prilocaine 2.5%) or ☐ LMX4 cream (Lidocaine 4%) Apply 1-2 hours before port access.	Qty: 30 Gram Refills: PRN x 1yr	☐ Other: _____	

MEDICATION	ROUTE	DOSE	DIRECTIONS	DAY SUPPLY	REFILLS
AMONDYS 45™	☒ IV	30 mg/kg	_____ mg every week (Rounded to the whole vial unless otherwise specified)	30	☒ 1 year

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

Infusion Volume: Add final drug does volume to 100-150mL 0.9% saline ☐ Other: _____

Infusion Rate: Over _____ minutes (Manufacturer recommended infusion duration between 35- 60 minutes)

Post Infusion: Flush IV with 25mL 0.9% saline at final rate of drug infusion

Vital Signs: At baseline and completion of post infusion flush. ☐ Other: _____

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

5 LAB ORDERS

☐ Urine for protein by dipstick monthly (prior to the infusion or 48 hours after infusion) _____
☐ Cystatin C every 3 months _____
☐ Other: _____

6 PROVIDER SIGNATURE

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

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AMONDYS 45 INFUSION REACTION MANAGEMENT ORDERS

Patient Name: _____

DOB: _____

7 EMERGENCY MEDICATIONS - #Q.S. REFILL X 1 YR OR ____ REFILLS

- ☒ 0.9% Saline 250mL – administer at 50mL/hr once infusion stops OR
- ☐ 0.9% Saline ____mL – administer at ____mL/hr once infusion stops
- ☐ For mild infusion reactions, give:
Acetaminophen 500mg po
Diphenhydramine 25-50mg po
- ☐ For moderate infusion reactions, give diphenhydramine 25-50mg IV
- ☐ For severe infusion reactions, give Solu-Medrol 1mg/kg IV prn
- ☐ Other infusion reaction medication protocol: _____
- ☒ For severe bronchospasm/anaphylaxis, administer appropriate Epinephrine Autoinjector IM and call 911.
Epinephrine 2-Pak 0.3mg Autoinjector IM for patients weighing $\geq$ than 30kg
Epinephrine 2-Pak 0.15mg Autoinjector IM for patients weighing $<$ than 30kg

EXAMPLES OF AMONDYS 45 INFUSION REACTIONS

- | | | | |
|----------------------|------------------|-------------------|--------------|
| • Anaphylaxis | • Angioedema | • Cough | • Fever |
| • Dizziness | • Abdominal Pain | • Nausea/Vomiting | • Rash |
| • Light-headedness | • Headache | • Diarrhea | • Joint Pain |
| • Oropharyngeal Pain | | | |

INSTRUCTIONS DURING REACTION

- 1) **STOP AMONDYS 45** and start 0.9% normal saline at 50mL/hr or at rate specified below:
☐ Other Rate: ____mL/hr
- 2) **ADMINISTER EMERGENCY MEDS FROM BOX 7 ACCORDING TO PHYSICIAN ORDERS**
☒ For severe anaphylaxis, administer appropriate Epinephrine Autoinjector IM – may repeat in 20 minutes if needed. Call 911.
- 3) **CALL PHYSICIAN**

8 PROVIDER SIGNATURE ("AMONDYS 45™ Infusion Reaction Management Orders")

X

Product Substitution Permitted Signature

Date of Signature

X

Dispense as Written Signature

Date of Signature

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