Niktimvo Prescription and Nursing Order

CVS specialty®

Fax Referral To: 1-855-297-1270 **Phone:** 1-888-280-1190
Address: 6020 Ave Roberto Sanchez Vilella Carolina, PR 00982 **NCPDP:** 4026325

1 PATIENT INFORMATION

First Name: _____ Last Name: _____ DOB: _____ Gender: _____ CVS Acct #: _____
Address: _____ City: _____ State: _____ ZIP: _____
Phone: _____ Allergies: _____ Weight: _____kg ICD-10: _____
☐ Start of treatment ☐ Continuation of therapy Requested Start Date: _____

2 PRESCRIBER INFORMATION

Prescriber Name: _____ Address: _____ City, State, ZIP: _____
NPI # _____ DEA # _____ Phone: _____ Fax: _____

3 SERVICE LOCATION – Pick one of the 3 below options (Drug, diluents, supplies, and nursing for drug administration or catheter maintenance)

☐ Home Infusion (Must have first two doses in a controlled setting)

For home infusion, must document date, location and outcome of first two doses:
Dose 1 – Date: _____ Location: _____
Outcome: ☐ Well tolerated
☐ Tolerated with mild to moderate infusion related reactions (rash, flushing, slowing or temporary interruption of infusion, treatment with antihistamines).
Dose 2 – Date: _____ Location: _____
Outcome: ☐ Well tolerated
☐ Tolerated with mild to moderate infusion related reactions (rash, flushing, slowing or temporary interruption of infusion, treatment with antihistamines).

** Please note: patients experiencing severe reaction on initial doses are not eligible for home infusion **

☐ Drug Only—Infusion will occur at hospital or AIS

4 PRESCRIPTION INFORMATION

Medication	Strength	Dose & Directions	Quantity	Refills
Axatilimab-csfr (Niktimvo)	50mg/mL SDV	Infuse 0.3 mg/kg IV over 30 minutes every 2 weeks (maximum dose of 35mg)	Quantity: _____	Refills: ___
		Other: _____	Quantity: _____	Refills: ___

5 Complete below if Home Infusion or AIS administration

Catheter	**Catheter Care** – flush only on drug admin days – SASH or PRN to maintain IV access & patency
☐ PIV (default if no selection)	**PIV** – NS 5mL (Heparin 10 units/mL 3-5ml if multiple days)
☐ Port	**Port** – NS 10mL & Heparin 100 units/mL 3-5ml
☐ PICC: # Lumens _____	**PICC** – NS 10mL & Heparin 100 units/mL 3-5mL + Maintenance flushes per lumen
☐ Other: _____	

Give as PIV if Port/PICC failure

PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute	May Substitute / Product Selection Permitted / Substitution Permissible
Prescriber's Signature: _____Date: _____	**Prescriber's Signature: _____Date: _____**

Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber. This form is not a valid prescription in Arizona.

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

CVS specialty®

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Phone: **1-866-899-1661** | Fax completed form: **1-866-843-3221**

Coram® CVS specialty infusion services

1 PATIENT INFORMATION

First Name: _____ Last Name: _____ DOB: _____ Gender: _____ CVS Acct #: _____

6 PREMEDICATIONS (Home Infusion or AIS administration)

Medication & Strength	Dose & Directions	Quantity	Refills
Diphenhydramine 25mg capsules	☐ 25mg PO 30 minutes prior to infusion	Quantity: 1 per infusion	Refills to match prescription(s) above
	☐ 50mg PO 30 minutes prior to infusion	Quantity: 2 per infusion	
Acetaminophen 325mg tablets	☐ 325mg PO 30 minutes prior to infusion	Quantity: 1 per infusion	
	☐ 650mg PO 30 minutes prior to infusion	Quantity: 2 per infusion	
Medication: _____	Directions: _____	Quantity: _____	
Medication: _____	Directions: _____	Quantity: _____	
Medication: _____	Directions: _____	Quantity: _____	

7a ACUTE INFUSION REACTION MEDICATIONS – HOME INFUSION
Fill out below if going to be infused at HOME and patient requires any other medication besides Epinephrine.

Medication & Strength	Dose & Directions	Quantity	Refills
☐ Epinephrine autoinjectors	Adult (>30kg): 0.3mg PRN severe allergic reaction. Call 911. May repeat in 5-15 minutes	Quantity: 2	Refills: 0
☐ Epinephrine autoinjectors	Pediatric (>15-30 kg): 0.15mg PRN severe allergic reaction. Call 911. May repeat in 5-15 minutes	Quantity: 2	Refills: 0
Pharmacy to determine dose based on patient weight (above). Leave on file if patient has in-date epinephrine on hand			
Medication: _____	Directions: _____	Quantity: _____	Refills to match prescription(s) above
Medication: _____	Directions: _____	Quantity: _____	
Medication: _____	Directions: _____	Quantity: _____	

7b ACUTE INFUSION REACTION MEDICATIONS – AIS (AIS will provide drug and supplies for the below if MD prescribes)
Fill out below if going to be infused at AIS and patient requires any other medication besides Epinephrine:

Medication & Strength	Dose & Directions	Quantity	Refills
☐ Epinephrine 1mg/mL amp (1:1000)	Adult (>30kg): 0.3mg PRN severe allergic reaction. Call 911. May repeat in 5-15 minutes		Refills to match prescriptions(s) above
☐ Epinephrine 1mg/mL amp (1:1000)	Pediatric (>15-30 kg): 0.15mg PRN severe allergic reaction. Call 911. May repeat in 5-15 minutes		
AIS to determine dose based on patient weight (above)			
☐ Diphenhydramine 50mg/1mL vial	Directions: _____		Refills to match prescriptions(s) above
☐ Diphenhydramine oral Liquid 12.5mg/5mL	Directions: _____		
☐ Acetaminophen oral	Directions: _____		
☐ Methylprednisolone univial (adult) 125mg	Directions: _____		
☐ Methylprednisolone univial (pediatric) 40mg	Directions: _____		
☐ NaCl 0.9% 10mL PFS	Directions: _____		
☐ 500mL NS with rate flow admin set	Directions: _____		
☐ Hydrocortisone univial (adult) 250mg	Directions: _____		
☐ Hydrocortisone univial (pediatric) 100mg	Directions: _____		

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8 PREPARATION AND ADMINISTRATION

Intravenous:

- Prior to administration, verify AIR medications are available at the site of infusion
- Note that patients are at risk of an infusion reaction with each infusion. AIR medications are required
- Validate patient's weight and review potential adverse reactions with patient
- Do not begin preparation until IV access has been established and or patency confirmed
- Venous Access - Peripheral unless otherwise specified in manufacturer information or patient has pre-existing central access
- Oral- Validate that premedications have been taken prior to mixing medication
- Injectable- Validate all injectable premedications are available and ready to administer prior to mixing medication
- Refer to manufacturer guidelines for filtering and administration device information
- Determine the dose and total volume of Niktimvo solution needed
- Withdraw the calculated volume of Niktimvo from the vial
- Dilute in sterile 0.9% Sodium Chloride to a final concentration of 0.24mg/mL to 0.75mg/mL
- Administer diluted Niktimvo solution as an intravenous infusion over 30 minutes through a dedicated infusion line that includes a sterile, low protein binding 0.2 micron in-line or add-on PES filter. Do not administer as an intravenous push or bolus
- After the infusion is complete, flush with sterile 0.9% Sodium Chloride Injection

Rx includes related diluents, pumps, DME, ancillary supplies (e.g., needles, syringes, dressings) as necessary for drug administration/catheter maintenance and nursing services for drug administration/therapy teach train or catheter maintenance.

IF HOME INFUSION – all drugs and supplies including pump if needed is sent.

IF AIS INFUSION –No AIR medications are needed to be sent. Send all other supplies including any premeds to AIS.

If pump is required for infusion - no pump is needed to be sent– only send 1) Curlin tubing 2) Pump sheet to nursing homecare to send with these orders

Additional Notes: _____

_____

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