ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

❑ Puyallup Infusion Center - Fax: 253-697-5066
❑ Gig Harbor Infusion Services - Fax: 253-530-8069
❑ Allenmore Ambulatory Infusion Services - Fax: 253-864-4052
❑ DHEC Infusion Center - Fax: 509-755-5845
❑ Auburn Infusion Services - Fax: 253-876-8282
❑ North Spokane Infusion Center - Fax: 509-232-2531

ORDERS WITH CHECK BOXES When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Emicizumab-kxwh (Hemlibra)

Patient Name:_____ Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ ❑ May leave message

ICD -10 Code:

Diagnosis: ❑ Hemophilia A with or without factor VIII inhibitors ❑_____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs and documentation
If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

Baseline and maintenance labs required: None

☑ **IV Access:** Access and/or maintain IV siten in accordance with MHS IV Therapy P&P: Peripheral IV Device Site Selection, Insertion, Maintenance, and Discontinuation; and Maintenance of Central Venous Catheters-Flushing, Dressing Changes and Removal.

Treatment Regimen:
❑ Emicizumab-kxwh (Hemlibra): Loading dose 3 mg/kg weekly x4 doses then:
❑ 1.5 mg/kg once every week
❑ 3 mg/kg once every two weeks
❑ 6 mg/kg once every four weeks

☑ **Vital Signs:** Check vital signs prior to and at completion of infusion.
Contact provider if systolic BP >180; diastolic BP >100; systolic BP <90; HR >110; temp >38C (100.4F)

If hypersensitivity develops (fever, chills, hypotension, rigors, itching, rash, etc.):
- Consult MultiCare Hypersensitivity guideline for treatment/management
- Notify provider of reaction, assessment and need for further orders

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: ❑ Yes ❑ No (if yes, please send DOCUMENTATION of consent with order)

Provider Signature	Print Name	Date	Time

Order expires in 12 months**

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order

HEMOPHILIA A

MultiCare

60-0362-4 (4/24)