Local Infusion

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ENJAYMO (SUTIMLIMAB-JOME) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____kg

Allergies: _____

❑ Patient has known difficult venous access. Comments:_____

DIAGNOSIS (Provider must specify)

❑ Cold Autoimmune Hemolytic Anemia, ICD 10: D59.12._____

❑ Other:_____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI:_____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO

❑ Benadryl 25mg PO

❑ Famotidine 20 mg IV

❑ Cetirizine (Zyrtec) 10 mg PO

❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Enjaymo	Dosing administered weekly for the first two weeks, then every two weeks thereafter: Patients weighing ≥39 kg and less than 75 kg: 6,500 mg Patients weighing ≥75 kg: 7,500 mg	IV	❑ Initial dosing: Once weekly for first 2 weeks, then every 2 weeks thereafter ❑ Maintenance dosing: Once every 2 weeks

❑ New Start Therapy ❑ Continuation of Therapy Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

FAX NUMBERS:

❑ CT: 203.433.0621
❑ FL: 904.877.9270
❑ MA: 413.296.8482
❑ MD: 240.224.8607
❑ ME: 207.407.7272
❑ NC: 919.984.8698
❑ NH: 603.217.5371
❑ NJ: 201.581.4521
❑ NY: 631.250.6020
❑ OH: 937.871.4594
❑ PA: 610.273.5998
❑ SC: 864.973.6279
❑ VA: 703.202.0499