Empliciti (elotuzumab)

Order Form
Rev. 06/28/2023

Infusion ASSOCIATES
Phone: (833) 394-0600
Fax: (833) 996-4888

PATIENT INFORMATION **Referral Status:** ○ New Referral ○ Updated Order ○ Order Renewal

Date: Patient Name: DOB:

Allergies: Weight (kg): Height (cm):

ICD-10 Code(s) & Description *(required)*:

☐ *(required)* The patient's demographics, insurance, lab results, meds and recent visit notes were sent to IA.

The patient has an existing prior authorization: ○ Yes *(please fax IA a copy)* ○ No *(IA will process for you)*

PRESCRIBING OFFICE

Contact Name: Contact Phone Number:

Ordering Provider: Provider NPI:

Practice Name: Phone: Fax:

CLINICAL HISTORY

In the past year, what medications for the above diagnosis has the patient tried and failed?

Drug & Dose	Dates of Use	Drug & Dose	Dates of Use

☐ *(required)* Which combination regimen is being prescribed?_____

☐ *(required)* Pathology/radiology results are attached.

Stage: _____ Line of therapy: _____

☐ *(required)* **Immunotherapy consent obtained and faxed with order**

Ordering provider is responsible for monitoring lab results including pregnancy screening, if applicable, during treatment. Please ensure timely notification if a treatment hold is indicated. **(833) 394-0600 option 6**

PRE-MEDICATION ORDERS *(All required)*

○ Diphenhydramine ○ PO or ○ IV ☐ 25mg or ☐ 50mg

○ Acetaminophen PO ☐ 650mg or ☐ 1000mg

○ Famotidine IV Push ☐ 20mg or ☐ 40mg

○ Dexamethasone IV Push 8mg

***** Patient should also be prescribed PO dexamethasone to be taken 3-24 hours prior.***

THERAPY ADMINISTRATION

Empliciti (elotuzumab) IV

Dose: **** IA does not administer initial dose of Empliciti due to risk of severe reaction with 1st dose ****

○ 10 mg/kg once weekly on days 8,15, and 22, then once every 2 weeks on days 1 and 15 of a 28-day cycle.

○ 10 mg/kg once weekly on days 8,15, and 22, then 20mg/kg once every 4 weeks on day 1 of a 28-day cycle.

Date of last infusion if not at IA: _____ RX Expiration Date: _____

Additional Notes from Referring Office:

_____ _____ _____

Provider Name (Print) **Provider Signature** **Date**