

Troy Infusion Center
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Troy, OH 45373
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Washington Township Infusion Center
1989 Miamisburg-Centerville Road
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Niktimvo® (axatilimab) Order Form
Epic Referral:

Patient Name: _____ **DOB:** _____

Address: _____

Phone: _____ **ICD-10 Diagnosis:** _____

Patient Weight _____ **lbs / kg** (should only be administered in patients weighing ≥ 40 kg)

Rx:

☐ Axatilimab 0.3 mg/kg (maximum dose: 35 mg) once every 2 weeks

Order good for: ☐ 6 months ☐ 1-year ☐ Other duration: _____

Pre-meds: given at each infusion (optional, recommended if a patient experiences a reaction)

☐ Tylenol 1000 mg po or ☐ Tylenol 650 mg po
☐ Benadryl _____ mg po or ☐ Benadryl _____ mg IV
☐ Other: _____

Lab Orders (include frequency):

☐ CMP, CPK, amylase, lipase at every visit (recommended)
☐ Urine hcG
☐ Other: _____

Port/PICC care per protocol will be performed if applicable including heparin flush (500 units/5mL) and cathflo (2 mg) PRN for patients with a port

Prescriber Printed Name: _____

Prescriber Full Address: _____

Office Phone Number: _____ **Office Fax Number:** _____

Prescriber Signature: _____ **Date:** _____