# Kanuma (sebelipase alfa)

**Provider Order Form** *rev. 1/2/2026*

AMERICAN INFUSION CARE
SPECIALTY INFUSION

## PATIENT INFORMATION

**Referral Status:** ☑ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

**Patient Status:** ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

**Patient Preferred Location:** _____

## DIAGNOSIS & CLINICAL INFORMATION

**ICD 10-Code & Description (**Provide full completed code & Description)

☐ E75.241 Lysomal acid lipase deficiency
☐ E75.5 Other lipid storage disorders
☐ E75.6 Lipid storage disorder, unspecified
☐ Other: _____

**REQUIRED DOCUMENTATION:** Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results ( CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.
☐ Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

## PRESCRIPTION INFORMATION

**Nursing:** Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

**Pre-Medications**

- Acetaminophen (Tylenol) ☐500mg ☐650mg ☐1000mgPO
- Cetirizine (Zyrtec) 10mgPO
- Loratadine (Claritin) 10mgPO
- Diphenhydramine (Benadryl) ☐25mg ☐50mg ☐PO ☐IV
- Methylprednisolone (Solu-Medrol) ☐40mg ☐125mg IV
- Other: _____ Dose: _____ Route: _____

**Lab Orders**

☐ Other: _____

**Kanuma (sebelipase alfa)** (Select one):

☐ **Infants with rapidly progressive LAL deficiency** *(Presenting within first 6 months of life)* ☐ **Pediatric & Adult patients with LAL deficiency**

**Dosing (Choose One):**

**Infants (< 6 months):**
☐ **1 mg/kg IV weekly**
☐ **3 mg/kg IV weekly** *(suboptimal response)*
☐ **5 mg/kg IV weekly** *(continued suboptimal response)*

**Pediatric & Adult:**
☐ **1 mg/kg IV every other week**
☐ **3 mg/kg IV every other week** *(suboptimal response)*

***Route:*** *IV infusion*
***Dose based on:*** *Weight (kg)*
***Infusion time:*** *Per protocol*

**Post Treatment Observations:** The patient is required to stay for 30 minutes following the first administration.

☐ **Refills:** ☐ zero ☐ 6 months ☐ 12 months
☐ _____
*(Prescription valid for one year, unless otherwise indicated)*

**Special Instructions:**_____

## PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

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

E: Referrals@americaninfusioncare.com
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Greater Houston Area F: 832.510.7824 P: 832.800.3213
McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454
Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213
Other Locations (Oaklawn, Lancaster, etc): F: 469.305.2361 P: 972.865.4454