Orsini

Specialty Pharmacy Services

Fax To: 877.339.4602 **Phone:** 800.356.5034

Vyondys 53™ INFUSION ORDER

(Golodirsen)

1 PATIENT INFORMATION

Patient Name: ____________________

Primary Phone: ____________ DOB: ____________

Allergy: ____________________

Gender: ☐ Male ☐ Female

Patient Weight: ____ Lbs ____ Kg Date Weighed: ________

Diagnosis: *G71.01 Muscular Dystrophy*

2 PRESCRIBER INFORMATION

Prescriber's Name: ____________________

State License #: ____________ NPI #: ____________

Address: ____________________

City, State, Zip: ____________________

Phone: ____________ Fax: ____________

Contact Person: ____________ Phone: ____________

3 CATHETER ACCESS AND FLUSH PROTOCOL

ACCESS TYPE	CATHETER FLUSH ORDERS	PORT OCCLUSION
☐ Peripheral ☐ PORT *(Also include Peripheral IV PRN Port Malfunction)*	**0.9% Saline Flush:** **Dispense:** 30 Days **Refills:** PRN x 1yr Flush line/port with 10mL for patency/SASH protocol. **Heparin Flush:** **Dispense:** 30 Days **Refills:** PRN x 1yr Flush port with _____ mL of Heparin _____ units/mL per SASH protocol.	**CathFlo:** 2mg/2mL as directed. *Pharmacy authorized to dispense upon home health nurse validated port occlusion.* ☐ **Dispense:** 1 Kit **Refills:** PRN x 1yr

4 TREATMENT REGIMEN

Administer pre-medication 30-60 min prior to drug infusion

PRE-MEDICATION

☐ Antipyretic: ____________________ **Qty:** 6 month **Refills:** PRN x 1yr

☐ Antihistamine: ____________________ **Qty:** 6 month **Refills:** PRN x 1yr

☐ EMLA (Lidocaine 2.5%/Prilocaine 2.5%) or ☐ LMX4 cream (Lidocaine 4%) **Qty:** 30 Gram **Refills:** PRN x 1yr ☐ Other: ____________

Apply 1-2 hours before port access.

MEDICATION	ROUTE	DOSE	DIRECTIONS	DAY SUPPLY	REFILLS
Vyondys 53™	☒ IV	30 mg/kg	____________ mg every week (Supplied as 50mg/mL vials)	30	☒ 1 year
Skilled Nursing Visit	☐ As needed for IV access, administration and proper clinical monitoring		Administration procedures to be followed per pharmacy protocol		

Infusion Volume: Add final drug dose volume to 100-150mL 0.9% saline. ☐ Other: ____________________

Infusion Rate: Over ________ minutes *(Manufacturer recommended infusion duration between 35-60 minutes)*
(Please Specify)

Post Infusion: Flush IV with 25mL 0.9% saline at final rate of drug infusion

Vital Signs: At baseline and completion of post infusion flush. ☐ Other: ____________________

☒ **Supplies**: Provide infusion pump if needed, IV Pole, back-up peripheral IV kit and all necessary infusion supplies

5 PROVIDER SIGNATURE

Product Substitution Permitted Signature ____________ Date of Signature ____________

Dispense as Written Signature ____________ Date of Signature ____________

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