Orsini Specialty Pharmacy

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VILTEPSO® (viltolarsen) injection

1 PATIENT INFORMATION

Patient Name: ______________________

Primary Phone: ______________ DOB: __________

Allergy: ______________________

Gender: Male Female

Patient Weight: ____ Lbs ____ Kg Date Weighed: ________

Diagnosis: *G71.01 Muscular Dystrophy*

1 PRESCRIBER INFORMATION

Prescribers 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 1 yr Flush line/port with 10mL for patency/SASH protocol. **Heparin Flush:** **Dispense:** 30 Days **Refills:** PRN x 1 yr 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

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.

☐ Pain Ease Spray (Ethyl Chloride): Use as directed prior to IV access **Qty:** 1 Bottle **Refills:** PRN x 1yr

MEDICATION	ROUTE	DOSE	DIRECTIONS	DAY SUPPLY	REFILLS
VILTEPSO	☒ IV	80 mg/kg	_____ mg every week. Supplied as 250 mg/5mL vials; prescriber to round to nearest 50mg increment.	28	☒ 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: Dilute to a final volume of 100mL with 0.9% NS / No dilution needed if drug volume over 100mL ☐ Other ____________

Infusion Rate: Over 60 minutes *(Manufacturer recommended infusion duration is 60 minutes)* ☐ Other ____________

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 LAB ORDERS

☐ Urine for protein by dipstick monthy (prior to the infusion or 48 hours after infusion): ____________

☐ Cystatin C every 3 months ____________

☐ Other ____________

6 PROVIDER SIGNATURE

Product Substitution Permitted Signature ____________ Date of Signature ____________

Dispense as Written Signature ____________ Date of Signature ____________

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