Orsini
Rare Disease Pharmacy Solutions

Fax To: (877) 286-3620 **Phone:** (800) 759-0445

VILTEPSO® INFUSION ORDER FORM

(viltolarsen)

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

Prescribers Name: ____________________

State License #: ____________ NPI #: ____________

Address: ____________________

City, State, Zip: ____________________

Phone: ____________ Fax: ____________

Contact Person: ____________ Phone: ____________

Contact Email: ____________________

3 CATHETER ACCESS AND FLUSH PROTOCOL

ACCESS TYPE	CATHETER FLUSH ORDERS	
Peripheral PORT *(Also include Peripheral IV for Port Malfunction)*	[X] **0.9% Saline Flush:** **Dispense:** 28 Days **Refills:** x 1 Yr OR ___ Refills Flush line/port with 10mL for patency/SASH protocol. **Heparin Flush:** **Dispense:** 28 Days **Refills:** x 1 Yr OR ___ Refills Patients < 20kg: Flush port with 3-5mL of Heparin 10units/mL per SASH protocol Patients > 20kg: Flush port with 3-5mL of Heparin 100units/mL per SASH protocol Alternative Heparin Order: ____________	**CathFlo:** 2 mg/2 mL as directed. *Pharmacy authorized to dispense upon home health nurse validated port occlusion.* **Dispense:** 1 Kit **Refills:** x 1 Yr OR___Refills

4 PRE-MEDICATION

Premedication for administration 30-60 min. prior to drug infusion:

- [ ] Antipyretic: ____________ q.s. 28 days **Refill:** x 1 Yr OR ___ Refills
- [ ] Anthistamine: ____________ q.s. 28 days **Refill:** x 1 Yr OR ___ Refills
- [ ] Corticosteroid: ____________ q.s. 28 days **Refill:** x 1 Yr OR ___ Refills
- [ ] LMX 4 or (EMLA) Lidocaine 2.5%/Prilocaine 2.5% cream - Apply topically 1 hour prior to starting IV or accessing port **QTY:** 1 **Refill**: x 1Yr OR___Refills
- [ ] Other Premedications: ____________

[ ] **No Premedication Needed**

5 TREATMENT REGIMEN

MEDICATION	ROUTE	DOSE	DIRECTIONS	DAY SUPPLY	REFILLS
VILTEPSO	[X] IV	80 mg/kg	______ mg every week. (Supplied as 250 mg/5mL vials; prescriber to round to nearest 50mg increment)	28	[X] 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 20mL 0.9% saline at final rate of drug infusion

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

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

6 SITE OF CARE

HOPD Only Home (Start Directly) HOPD-->Home after_____ infusions in HOPD

7 LAB ORDERS

- [ ] Urine for protein by dipstick monthy (prior to the infusion or 48 hours after infusion) or ____________
- [ ] Serum cystatin C every 3 months or ____________
- [ ] Protein and Creatinine Random Urine to measure UPCR every 3 months or ____________
- [ ] Other ____________

ALSO SEE PAGE 2 (VILTEPSO INFUSION REACTION MANAGEMENT ORDERS)

8 PROVIDER SIGNATURE ("VILTEPSO Infusion Order")

Product Substitution Permitted Signature ____________ Date of Signature ____________

Dispense as Written Signature ____________ Date of Signature ____________

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VILTEPSO® INFUSION REACTION MANAGEMENT ORDERS

Patient Name: ______________________________ DOB: ______________

9 EMERGENCY MEDICATIONS - #Q.S. REFILL X 1 YR OR ____ REFILLS

☒ 0.9% Saline 250mL – administer at 50mL/hr once infusion stops OR
☐ 0.9% Saline _____mL – administer at ______ml/hr once infusion stops

☐ **For mild infusion reactions**, give:
Acetaminophen 500mg po
Diphenhydramine 25-50mg po
☐ **For moderate infusion reactions**, give diphenhydramine 25-50mg IV
☐ **For severe infusion reactions**, give Methylprednisolone 1mg/kg IV prn
☐ **Other infusion reaction medication protocol:** ______________________________

☒ **For severe bronchospasm/anaphylaxis, administer appropriate Epinephrine Autoinjector IM and call 911.**
Epinephrine 2-Pak 0.3mg Autoinjector IM for patients weighing ≥ than 30kg
Epinephrine 2-Pak 0.15mg Autoinjector IM for patients weighing < than 30kg

EXAMPLES OF VILTEPSO INFUSION REACTIONS

- Upper Respiratory Infection
- Itching
- Abdominal Pain
- Diarrhea
- Fever and/or Chills
- Cough
- Vomiting
- Injection Site Reactions
- Joint Pain
- Rash or Hives
- Flushing

INSTRUCTIONS DURING REACTION

1) STOP VILTEPSO and start 0.9% normal saline at 50mL/hr or at rate specified below:
☐ Other Rate: _____mL/hr

2) ADMINISTER EMERGENCY MEDS FROM BOX 9 ACCORDING TO PHYSICIAN ORDERS
☒ For severe anaphylaxis, administer appropriate Epinephrine Autoinjector IM – may repeat in 20 minutes if needed. Call 911.

3) CALL PHYSICIAN

10 PROVIDER SIGNATURE ("VILTEPSO® Infusion Reaction Management Orders")

X ______________________________
Product Substitution Permitted Signature — Date of Signature

X ______________________________
Dispense as Written Signature — Date of Signature

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