GOLODIRSEN (VYONDYS 53®) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to: (410) 558-6439

YOUR INTELLIGENT HEALTH COMPANY. UBACARE	**Patient Name:**			**Date of Birth:**	
	Address:				
	Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description: Duchenne muscular dystrophy (DMD) | **ICD-10 Code:** G71.01

Golodirsen (VYONDYS 53®) Prescription

Golodirsen (VYONDYS 53®) refill as directed x 1 year

Infuse 30 mg/kg IV over 35 to 60 minutes every week (+/− 3 days to allow for patient/nurse scheduling).

Dose will be rounded to closest 100 mg.

Flush IV tubing with NS 10 to 20 mL after each infusion.

Prescriber will obtain weight for non-ambulatory patients and provide dose changes to pharmacy as needed.

Ancillary Orders

Anaphylaxis Kit

If this is a 1st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?

☐ Yes – please complete Anaphylaxis Physician Order (FR-PC-036) ☐ No

Medication Orders

☐ Lidocaine/prilocaine 2.5%/2.5% (or equivalent) anesthetic cream 30 gm – apply topically 30 min prior to venipuncture or port access as needed for numbing.

☐ Other: _____

IV Flush Orders

☐ Peripheral: ***2 to 20 kg:*** NS 1 mL pre-/post-use and 1 to 3 mL pre-/post-lab draw.
> 20 kg: NS 1 to 3 mL pre-/post-use and 3 to 5 mL pre-/post-lab draw.

☐ Implanted Port: ***< 12 y.o.:*** NS 1 to 3 mL pre-/post-use and 3 to 5 mL pre-/post-lab draw. Heparin (10 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (10 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.
≥ 12 y.o.: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

☐ Monthly proteinuria by dipstick, every 3 months serum cystatin C.

☐ No labs ordered at this time.

☐ Other: _____

Skilled nurse to assess and administer and/or teach self-administration, where appropriate, via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:	**Phone:**	**Fax:**
Address:	**NPI:**	
City, State: **Zip:**	**Office Contact:**	