

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:

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