Viltolarsen (Viltepso) Patient Referral Form

Patient Demographics Information

Patient Name		SSN#	DOB
Patient Address			
Primary Phone	Cellular Phone	Work Phone	
Emergency Contact Name, Relationship		Emergency Contact Phone Number	

Additional Documentation Needed

- Copy of insurance cards
- Patient face sheet w/demographics
- Kidney Function utilizing serum cystatin C, urine dipstick, or urine-to-creatinine ratio
- History and Physical
- CBC w/diff, BMP, & CMP
- Recent vitals including blood pressure
- Confirmation of DMD gene mutation

Patient Insurance Information

Insurance Plan #1			Insurance Plan #2		
Subscriber Name		DOB	Subscriber Name		DOB
Policy Number	Group ID		Policy Number	Group ID	

Patient Clinical Information

Gender ☐M ☐F	Height (inches)	Weight (lbs.)	Allergies (food/drug)

Statement of Medical Necessity / Primary Diagnosis

ICD10: Description of diagnosis:

Medication Information / Prescription and Orders

Medication:

Viltepso

Directions:

Infuse intravenously per manufacturer guidelines over 60 minutes.
*If calculated dose is less than 100 mL, dilute with sodium chloride 0.9% to a total volume of 100 mL. If calculated dose is 100 mL or more, further dilution not required.

□ DMD dosing: ________ mg (80mg/kg) intravenously once weekly.

□ Other dosing: ________ mg intravenously every ____ week(s)

*If patient is currently taking Viltepso, date of last dose:

Quantity/Refills

Dispense: #4 doses (one month)
+ _____ refills

☐ Other

Premedication(s)

☐ Give premedication(s) 30 minutes prior to infusion (generics will be dispensed)

diphenhydrAMINE	☐ Pediatric Dosing: ________mg (1mg/kg/dose) PO	☐ Adult Dosing: 25-50mg PO
Acetaminophen	☐ Pediatric Dosing: ________mg (10-15mg/kg/dose) PO	☐ Adult Dosing: 325-650mg PO
Other:	☐ ________________ (medication name): ____________________________________ (dosing)	

☐ Lidocaine 2.5% and Prilocaine 2.5% topical cream: Apply to IV site prior to access PRN for pain upon needle insertion.

☐ Other (prescriber to specify):

Quantity/Refills

Dispense: #QS + 12 refills
unless otherwise noted

☐ Other

Line Access

RN to start peripheral IV or use existing CVAD. RN to administer catheter flushing and medications per medication order.

☐ Sodium Chloride 0.9% 10 mL Flush: Flush with 2-10 mL sodium chloride 0.9% IV before and after medication administration or every 24 hours while IV access in place.

☐ Sodium Chloride 0.9% 10 mL STERILE Flush: Flush with 5-10 mL STERILE sodium chloride 0.9% as needed for port access

☐ Heparin Lock **10 units/mL** 5 mL Flush: Lock with 2-5 mL heparin **10 units/mL** after each use or daily while port accessed.

☐ Heparin Lock **100 units/mL** 5 mL Flush: Lock with 2-5 mL heparin **100 units/mL** after each use or daily while port accessed.

Quantity/Refills

Dispense: quantity #QS
PRN refills
unless otherwise noted

☐ Other

Adverse Reaction Orders

- If infusion reaction(s) occur, pause infusion for 10 minutes, then resume infusion at previously tolerated rate and use appropirate medical management If reaction(s) continue, stop infusion and notify physician.

Prescriber Information

Physician Name			Office Contact	
Practice Address				
NPI#	License #		Practice Phone	
Physician Signature Required - Substitution Permitted	Date		Physician Signature Required - Dispense as Written	Date