HERITAGE SPECIALTY PHARMACY

# Mepsevii (vestronidase alfa-vjbk) Patient Referral Form

Admissions Fax # 844-878-6917

Admissions Phone # 855-WE-R-RARE (855-937-7273)

## 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 ■ History and Physical

## 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 | Height (inches) | Weight (lbs) | Allergies (food/drug) |
|---|---|---|---|
| ☐M ☐F | | | |

## Statement of Medical Necessity / Primary Diagnosis

ICD10 Description of diagnosis Line Access ☐PIV ☐Port/CVAD

## Medication Information / Prescription and Orders

| Medication | Dosing | Quantity / Refills |
|---|---|---|
| Mepsevii (vestronidase alfa-vjbk) | _____ (4mg/kg) IV every 2 weeks<br>Infuse over 4 hours per manufacturer guidelines<br>Titrate rate per pharmacy rate table provided<br>Administering RN to monitor patient for at least 15 minutes post infusion | Dispense:<br>1 month supply, refill x12mos unless otherwise noted<br>☐Other |

### Line Access

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

☐Sodium Chloride 0.9% 10 mL Flush: Flush with 2-10 mL sodium chloride 0.9% IV before 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% IV as needed for port access.

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

### Quantity / Refills

Quantity #QS + PRN refills unless otherwise noted

☐Other

### Premedications

☐Give premedication(s) 30 minutes prior to infusion. *(If liquid selected, entire bottle will be dispensed)*

Antipyretic: Acetaminophen 325mg tab:☐325-650 mg PO **OR** 160mg/5mL liquid:☐_____ mg (10-15mg/kg/dose) PO

Antihistamine (non-sedating): Cetirizine 10mg tab:☐10 mg PO **OR** 100mg/mL liquid:☐_____ mg (2.5-5mg) PO

Fexofenadine 180mg tab:☐180 mg PO **OR** 30mg/5mL liquid:☐_____ mg (15-60mg) PO

Loratadine 10mg tab:☐10 mg PO **OR** 5mg/5mL liquid:☐_____ mg (5-10mg) PO

### Notes to Infusion RN

■ Administering RN to observe patient for at least 15 minutes after the infusion to assess for development of anaphylaxis.

■ An in-date EPINEPHrine dose must be in the home prior to initiation of infusion.

### Adverse Reaction Orders

In the event of an infusion reaction (ie: fever, chills, backache, headache, rigors) the following orders will be followed and physician will be notified.

■ Mild reaction: Give diphenhydrAMINE 50 mg PO x1 dose and slow infusion. If needed, give an additional dose of diphenhydrAMINE 50 mg PO x1 dose (Max 2 doses).

■ Moderate reaction: Give diphenhydrAMINE 50 mg po x1 dose and stop infusion; Sodium Chloride 0.9% 250mL IV wide open as needed.

■ Severe reaction (w/breathing problems): Stop infusion, give diphenhydrAMINE 50mg IM x1 dose and EPINEPHrine IM 0.3mg or 0.15mg. (per pt wt), and call 911.

## 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 |