Mepsevii (vestronidase alfa-vjbk) 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
- 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

Medication Information / Prescription and Orders

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

Line Access

Line Type: ☐ PIV ☐ Port/CVAD

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, call 911, and give diphenhydrAMINE 50mg IM x1 dose and EPINEPHrine IM 0.3mg or 0.15mg. (per pt wt)

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