HERITAGE SPECIALTY PHARMACY

Viltolarsen (Viltepso) 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
- 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.

Quantity/Refills
Dispense: #4 doses (one month)
+ _____ refills
☐ Other

□ DMD dosing: _____ mg (80mg/kg) intravenously once weekly. *If patient is currently taking Viltepso, date of last dose:

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

Premedication(s)

Quantity/Refills
Dispense: #QS + 12 refills
unless otherwise noted
☐ Other

☐ 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.

☐ Alteplase (Cathflo Activase) 2mg vial: Prior to use, reconstitute according to manufacturer recommendations. Instill alteplase 2mg in CVAD and dwell for 30 minutes. If unsuccessful, allow to continue dwelling for a total of 60 minutes. If still unsuccessful, notify pharmacy for next steps. Pharmacy will contact ordering provider if alteplase is used. Dispense qty: #1 vial + 1 refill, unless otherwise noted

☐ Other (prescriber to specify):

Line Access

Line Type: ☐ PIV ☐ Port/CVAD

Quantity/Refills
Dispense: quantity #QS
PRN refills
unless otherwise noted
☐ Other

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 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.

Adverse Reaction Orders

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

Prescriber Information

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