

EXONDYS 51™ INFUSION ORDER

(Eteplirsen)

1 PATIENT INFORMATION

Patient Name: _____
 Primary Phone: _____ DOB: _____
 Allergy: _____
 Gender: Male Female
 Patient Weight: ____ Lbs ____ Kg Date Weighed: _____
 Diagnosis: G71.0 Muscular Dystrophy

2 PRESCRIBER INFORMATION

Prescriber's Name: _____
 State License #: _____ NPI #: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____ Fax: _____
 Contact Person: _____ Phone: _____

3 CATHETER ACCESS AND FLUSH PROTOCOL

ACCESS TYPE	CATHETER FLUSH ORDERS	PORT OCCLUSION
<input type="checkbox"/> Peripheral <input type="checkbox"/> PORT (Also include Peripheral IV PRN Port Malfunction)	0.9% Saline Flush: Dispense: 30 Days Refills: PRN x 1yr Flush line/port with 10mL for patency/SASH protocol. Heparin Flush: Dispense: 30 Days Refills: PRN x 1yr Flush port with ____ mL of Heparin ____ units/mL per SASH protocol.	CathFlo: 2mg/2mL as directed. <i>Pharmacy authorized to dispense upon home health nurse validated port occlusion.</i> <input type="checkbox"/> Dispense: 1 Kit Refills: PRN x 1yr

4 TREATMENT REGIMEN

Administer pre-medication 30-60 min prior to drug infusion

PRE-MEDICATION

Antipyretic: _____ Qty: 6 month Refills: PRN x 1yr
 Antihistamine: _____ Qty: 6 month Refills: PRN x 1yr
 EMLA (Lidocaine 2.5%/Prilocaine 2.5%) or LMX4 cream (Lidocaine 4%) Qty: 30 Gram Refills: PRN x 1yr Other: _____
Apply 1-2 hours before port access.

MEDICATION	ROUTE	DOSE	DIRECTIONS	DAY SUPPLY	REFILLS
Exondys 51™	<input checked="" type="checkbox"/> IV	30 mg/kg	_____mg every week (Supplied as 50mg/mL vials)	30	<input checked="" type="checkbox"/> 1 year

Skilled Nursing Visit As needed for IV access, administration and proper clinical monitoring Administration procedures to be followed per pharmacy protocol

Infusion Volume: Add final drug dose volume to 100-150mL 0.9% saline. Other: _____

Infusion Rate: Over _____ minutes (Manufacturer recommended infusion duration between 35-60 minutes)
 (Please Specify)

Post Infusion: Flush IV with 25mL 0.9% saline at final rate of drug infusion

Vital Signs: At baseline and completion of post infusion flush. Other: _____

Supplies: Provide infusion pump if needed, IV Pole, back-up peripheral IV kit and all necessary infusion supplies

5 PROVIDER SIGNATURE

Product Substitution Permitted Signature _____ Date of Signature _____ Dispense as Written Signature _____ Date of Signature _____

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by the express authority of the sender to the named addressee.