


GOLODIRSEN (VYONDYS 53®) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to: **(410) 558-6439**

 option care health	Patient Name: _____	Date of Birth: _____
	Address: _____	
	Phone: _____	Height: _____ <input type="checkbox"/> inches <input type="checkbox"/> cm

Clinical Information

Primary Diagnosis Description: Duchenne muscular dystrophy (DMD)	ICD-10 Code: G71.01
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Allergies: _____

Golodirsen (VYONDYS 53®) Prescription

Golodirsen (VYONDYS 53®) refill as directed x 1 year

Infuse 30 mg/kg IV over 35 to 60 minutes every week (+/- 3 days to allow for patient/nurse scheduling).

Dose will be rounded to closest 100 mg.

Flush IV tubing with NS 10 to 20 mL after each infusion.

Prescriber will obtain weight for non-ambulatory patients and provide dose changes to pharmacy as needed. Prescriber will arrange monthly dipstick proteinuria monitoring.

Ancillary Orders

Anaphylaxis Kit

If this is a 1st infusion dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?

Yes No

- Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
 - Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
 - Normal saline 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. Patients ≤ 30 kg, infuse over 2 to 4 hours PRN headache rated > 5 on pain scale.

Medication Orders

- Lidocaine/prilocaine 2.5%/2.5% (or equivalent) anesthetic cream 30 gm – apply topically 30 min prior to venipuncture or port access as needed for numbing.
- Other: _____

IV Flush Orders

- Peripheral: NS 2 to 3 mL pre-/post-use.
- Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed. If unable to obtain implanted port access, it is acceptable to establish a peripheral IV access and administer peripherally.

Lab Orders

- Serum cystatin C every 3 months.
- No labs ordered at this time.
- Other: _____

Skilled nurse to assess and administer and/or teach self-administration, where appropriate, via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name: _____	Phone: _____	Fax: _____
Address: _____	NPI: _____	
City, State: _____	Zip: _____	Office Contact: _____

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