

ETEPLIRSEN (EXONDYS 51®) PRESCRIBER ORDER FORM			
Patient Name:		Date of Birth:	Gender:
Address:			
Phone:	Height: _____ <input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: _____ <input type="checkbox"/> lbs <input type="checkbox"/> kg Date weight obtained: _____	
Clinical Information			
Primary Diagnosis Description: Duchenne muscular dystrophy (DMD)		ICD-10 Code: G71.01	
Allergies:			
Eteplirsen (EXONDYS 51®) Prescription			
Eteplirsen (EXONDYS 51®) 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 0.9% Sodium Chloride 10 to 20 mL after each infusion. Prescriber will obtain weight for non-ambulatory patients and provide dose changes to pharmacy as needed.			
Ancillary Orders			
Anaphylaxis Kit Does this patient require an anaphylaxis kit? <input type="checkbox"/> Yes, with 1 st dose <input type="checkbox"/> Yes, with all doses Dosage: <ul style="list-style-type: none"> ▪ 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 – 25mg max per dose) IV or IM; repeat x 1 in 15 min PRN no improvement. ▪ 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. 			
Medication Orders <input type="checkbox"/> 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. <input type="checkbox"/> Other: _____			
IV Flush Orders <input type="checkbox"/> Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use. <input type="checkbox"/> Implanted Port: 0.9% Sodium Chloride 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 <input type="checkbox"/> No labs ordered at this time. <input type="checkbox"/> Other: _____			
Skilled nurse to assess and administer via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year. If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.			
<i>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>			
Prescriber Signature: _____		Date: _____	
Prescriber Information			
Prescriber Name:		Phone:	Fax:
Address:		NPI:	
City, State:	Zip:	Office Contact:	
Fax completed form, insurance information, and clinical documentation to: (410) 558-6439			
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