Dear Provider,

Specialty therapies can be complex, and complete information is essential to help ensure timely access to care.

The following prescriber order form is designed to capture the necessary clinical and patient information the dispensing pharmacy requires to begin the applicable prescribed therapy.

If your patient has elected to use Option Care Health, please fax completed form and required clinical documentation to **(800) 491-9561 or eFax-VyjuvekReferral@optioncare.com**.

Sincerely,
Option Care Health

VYJUVEK™ PRESCRIBER ORDER FORM *(28 DAY DISPENSE)*

Patient Name:	**DOB:**	**Gender:**
Address:		

Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

Allergies: ☐ NKDA OR (List):

Vyjuvek Prescription

Dosage:

☐ **Less than 3 years: Apply up to 1 mL of prepared VYJUVEK gel topically once weekly (+/− 3 days to allow for patient/nurse scheduling) to selected wounds until they are closed.** Discard remaining excess gel from vial.

☐ **Age 3 years & older: Apply up to 2 mL of prepared VYJUVEK gel topically once weekly (+/− 3 days to allow for patient/nurse scheduling) to selected wounds until they are closed.** Discard remaining excess gel from vial.

Apply VYJUVEK evenly to selected wound(s) in a grid pattern with droplets spaced approximately 1cm apart. Cover with a hydrophobic dressing.

Dispense four prepared doses of VYJUVEK gel syringes to a final concentration of 5 x 10^9 PFU/2.5mL. **Refills** _____

If planned dose is missed, administer dose ASAP and reset dosing schedule to weekly after the missed dose was administered.

Wound Selection and Prioritization

☐ Prescriber to choose wound areas for treatment. Patient/caregiver will perform wound care/cleansing and apply outer dressings as directed.

Number wound areas in order of priority for treatment (please choose at least 5 areas):

____Abdomen ____Arm L ____Arm R ____Back (lower) ____Back (upper) ____Buttocks ____Chest ____Foot L ____Foot R

____Groin ____Hand L ____Hand R ____Head/Face ____Leg L ____Leg R ____Neck ____Shoulder/Axilla L ____Shoulder/Axilla R

OR

☐ Patient/caregiver to determine wounds to be prioritized, perform wound care/cleansing, and apply outer dressings as directed by the prescriber.

Nursing Orders (where applicable)

☐ The patient or caregiver has been taught to independence with VYJUVEK application. Patient/caregiver will provide updates on wound status and photos as needed.

OR

☐ The patient will require nursing services for application of VYJUVEK and/or teaching VYJUVEK application to independence.

Skilled nurse to assess wounds and administer VYJUVEK to open wounds as indicated above. Patient/Caregiver will have wounds ready for VYJUVEK application and will redress wounds after administration and hydrophobic dressing application. The nurse will provide ongoing support and assistance as needed. The nurse will contact the prescriber as needed for any new, re-opened, or concerning wounds.

The nurse will use a hydrophobic dressing to cover the wound post gel application to be left in place until next dressing change.

The nurse will use Option Care Health's secure email platform to send photos of the wound(s) every 4 weeks and as needed to the prescriber at _____ (email address). Photos are used to track progress, address concerns and for insurance reauthorization.

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:**

