Orsini
Rare Disease Pharmacy Solutions

Fax To: 877.339.4602 Phone: 800.356.5034

EXONDYS 51® INFUSION ORDER

(eteplirsen)

1 PATIENT INFORMATION

Patient Name: _____

Primary Phone: _____ DOB: _____

Allergy: _____

Gender: ☐ Male ☐ Female

Patient Weight: ____ Lbs ____ Kg Date Weighed: _____

Diagnosis: *G71.01 Duchenne/Becker 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
☐ Peripheral ☐ 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. *Pharmacy authorized to dispense upon home health nurse validated port occlusion.* ☐ **Dispense:** 1 Kit **Refills:** PRN X 1yr

4 TREATMENT REGIMEN

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

PRE-MEDICATION	CATHETER FLUSH ORDERS
☐ 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%) *Apply 1-2 hours before port access.*	**Qty:** 30 Gram **Refills:** PRN x 1yr ☐ Other: _____

MEDICATION	ROUTE	DOSE	DIRECTIONS	DAY SUPPLY	REFILLS
EXONDYS 51®	☒ IV	30 mg/kg	_____ mg every week (Rounded to the whole vial unless otherwise specified)	30	☒ 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 does volume to 100-150mL 0.9% saline ☐ Other: _____

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

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 LAB ORDERS

☐ Urine for protein by dipstick monthy (prior to the infusion or 48 hours after infusion) _____

☐ Cystatin C every 3 months _____

☐ Other: _____

6 PROVIDER SIGNATURE

Product Substitution Permitted Signature _____ Date of Signature

Dispense as Written Signature _____ Date of Signature

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EXONDYS 51 INFUSION REACTION MANAGEMENT ORDERS

Patient Name: _____ DOB: _____

7 EMERGENCY MEDICATIONS - #Q.S. REFILL X 1 YR OR ____ REFILLS

☒ 0.9% Saline 250mL – administer at 50mL/hr once infusion stops OR
☐ 0.9% Saline ____mL – administer at _____ml/hr once infusion stops

☐ **For mild infusion reactions**, give:
Acetaminophen 500mg po
Diphenhydramine 25-50mg po

☐ **For moderate infusion reactions**, give diphenhydramine 25-50mg IV
☐ **For severe infusion reactions**, give Solu-Medrol 1mg/kg IV prn
☐ **Other infusion reaction medication protocol:** _____

☒ **For severe bronchospasm/anaphylaxis, administer appropriate Epinephrine Autoinjector IM and call 911.**
Epinephrine 2-Pak 0.3mg Autoinjector IM for patients weighing ≥ than 30kg
Epinephrine 2-Pak 0.15mg Autoinjector IM for patients weighing < than 30kg

EXAMPLES OF EXONDYS 51 INFUSION REACTIONS

- Bronchospasm
- Itching
- Malaise
- Chest Pain
- Headache
- Fever
- Cough
- Vomiting
- Dehydration
- Tachycardia
- Rash
- Flushing

INSTRUCTIONS DURING REACTION

1) STOP EXONDYS 51 and start 0.9% normal saline at 50mL/hr or at rate specified below:
☐ Other Rate: ____mL/hr

2) ADMINISTER EMERGENCY MEDS FROM BOX 7 ACCORDING TO PHYSICIAN ORDERS
☒ For severe anaphylaxis, administer appropriate Epinephrine Autoinjector IM – may repeat in 20 minutes if needed. Call 911.

3) CALL PHYSICIAN

8 PROVIDER SIGNATURE ("EXONDYS 51® Infusion Reaction Management Orders")

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

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