

1 PATIENT INFORMATION Patient Name: _____ Phone: _____ Address: _____ City: _____ State: _____ Zip: _____ MRN #: _____ DOB: _____ Drug Allergies: _____	2 PRESCRIBER INFORMATION Prescriber's Name: _____ DEA#: _____ NPI: _____ Clinic/Facility Name: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____
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3 Instructions to Provider
 All orders with ✓ will be placed unless otherwise noted. Please fax completed order form to 206-326-2139. For drug prior authorization, call 1-888-767-4670 or visit <https://wa-provider.kaiserpermanente.org/provider-manual/clinical-review/preservice>.

4 CLINICAL INFORMATION
 Diagnosis (ICD-10 code): _____ Date of Last Dose: _____

5 DUCHENNE MUSCULAR DYSTROPHY (DMD) PRESCRIPTION INFORMATION
 First Dose: No Yes, first dose must be given in Infusion Center Weight: _____ kg Date Recorded: _____
 Casimersen (Amondys 45) in 0.9% Sodium Chloride Injection
 Eteplirsen (Exondys 51) in 0.9% Sodium Chloride Injection
 Golodirsen (Vyondys 53) in 0.9% Sodium Chloride Injection
 Dose and Frequency: 30 mg/kg once weekly _____ mg/kg x weight (kg) once weekly Route: Intravenous
 Refills: 11 months Other _____
 Infusion Access: PIV CVAD Other: _____
 Patient's Current Home Care/Specialty Pharmacy: _____
Infusion Reaction Medications & Supplies
 Hydrocortisone sodium succinate injectable 100 mg IV **Diphenhydramine injectable 25 mg IV**
 Sig: Once PRN for hypersensitivity Sig: Once PRN, may repeat x1 for urticaria, pruritis, shortness of breath
 Epinephrine Auto-Injector 0.15mg 0.3mg QTY: 2
 Sig: Inject into lateral thigh muscle for severe allergic reaction. Seek medical attention after use. **Sodium Chloride 0.9% IV 250ml Bag**
 Sig: Once PRN for anaphylaxis
 Sodium Chloride 0.9% IV Flush: Flush 10 ml IV before/after medication administration or as needed for line maintenance
 Labs /Special Instructions/Pre-Meds: _____

Infusion Protocol: <ul style="list-style-type: none"> • Infuse per manufacturer guidelines • Monitor vital signs (Temp, BP, HR, RR) every 15 minutes x 4; then every 30 minutes x2; then every 60 minutes until completion of infusion • Documentation must include: <ul style="list-style-type: none"> ○ Start and end time of infusion ○ All rate changes, vital signs, including initial and final set ○ Patient response 	<ul style="list-style-type: none"> • Observe patient for signs of infusion rate-related adverse reactions: <ul style="list-style-type: none"> ○ Blood pressure changes, increased pulse rate ○ Fever, chills ○ Headache ○ Chest, back or hip pain ○ Dyspnea ○ Mild erythema
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6 PHYSICIAN SIGNATURE REQUIRED	
X	X
SUBSTITUTION PERMITTED (Date)	DISPENSE AS WRITTEN (Date)