

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 EXONDYS 51 PRESCRIPTION INFORMATION

First Dose: No Yes
Eteplirsen (EXONDYS 51) in 0.9% Sodium Chloride Injection
 Dose: 30 mg/kg _____ mg/kg x weight (kg)
 Frequency: Once weekly
 Refills: 11 months Other _____
 Infusion Access: PIV CVAD Other: _____
 Patient's Current Home Care/Specialty Pharmacy: _____

Weight: _____ kg Date Recorded: _____
 Route: Intravenous

Infusion Reaction Medications

Hydrocortisone sodium succinate injectable 100 mg IV
 Sig: Once PRN for hypersensitivity

Epinephrine Auto-Injector 0.15mg 0.3mg QTY: 2 **Diphenhydramine injectable 25 mg IV**
 Sig: Inject into lateral thigh muscle for severe allergic reaction. Seek medical attention after use. Sig: Once PRN, may repeat x1 for urticaria, pruritis, shortness of breath.

Other: _____

Infusion Supplies

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 _____ (Date)	X _____ (Date)
SUBSTITUTION PERMITTED	DISPENSE AS WRITTEN

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