



# Viltepso Prescription Order/Nursing Order

Fax Referral To: 1-877-232-5455

Phone: 1-808-254-2727

Address: 3375 Koapaka Street, Suite D105 Honolulu, HI 96819

NCPDP: 1203417

## 1) PATIENT INFORMATION

|                                             |                                                  |                       |         |                |
|---------------------------------------------|--------------------------------------------------|-----------------------|---------|----------------|
| First Name:                                 | Last Name:                                       | DOB:                  | Gender: | CVS Account #: |
| Address:                                    |                                                  | City:                 | State:  | ZIP:           |
| Phone:                                      | Allergies:                                       | Weight:               |         | ICD-10:        |
| <input type="checkbox"/> Start of treatment | <input type="checkbox"/> Continuation of therapy | Requested Start Date: |         |                |

## 2) PRESCRIBER INFORMATION

|                  |          |                   |
|------------------|----------|-------------------|
| Prescriber Name: | Address: | City, State, ZIP: |
| NPI #            | DEA #    | Phone: Fax:       |

## 3) INSURANCE INFORMATION Please fax copy if prescription and insurance cards with this form, if applicable (front and back)

|                                                                                             |            |                                                                                                                      |                          |
|---------------------------------------------------------------------------------------------|------------|----------------------------------------------------------------------------------------------------------------------|--------------------------|
| Is this Patient insured? <input type="checkbox"/> Yes <input type="checkbox"/> No           |            | Is this patient enrolled or eligible for Medicare/Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No |                          |
| Policy Holder's Name:                                                                       |            | Policy Holder's DOB:                                                                                                 | Relationship to Patient: |
| Medical Insurance:                                                                          | Telephone: | Policy ID:                                                                                                           | Group#:                  |
| Prescription Insurance:                                                                     |            | Prescription Plan Telephone:                                                                                         |                          |
| Policy ID:                                                                                  | Group#:    | RX BIN#:                                                                                                             | RX PCN#:                 |
| <input type="checkbox"/> Check box if patient is enrolled in manufacturer copay assistance, |            | If yes, please provide ID#                                                                                           |                          |

## 4) SERVICE LOCATION

|                                        |                                       |                                                                                         |
|----------------------------------------|---------------------------------------|-----------------------------------------------------------------------------------------|
| <input type="checkbox"/> Home Infusion | <input type="checkbox"/> Coram AIS    | (Drug, Diluents, Supplies, and Nursing for drug administration or catheter maintenance) |
| <input type="checkbox"/> MD Office     | <input type="checkbox"/> Other: _____ | Drug-only shipment for facility administration                                          |
| Address:                               |                                       | Contact:                                                                                |
| City:                                  | State:                                | ZIP: Ph#:                                                                               |

**If HOME Infusion** – all medications, supplies, pump program, and pump to be provided by CVS Specialty to patient, if needed.

**If CORAM AIS Infusion** – all medications (except AIR protocol), supplies, and pump program will be provided by CVS Specialty to patient if needed. (AIR protocol and pump provided by Coram)

**If MDO or Other Infusion Suite** – only medication to be provided by CVS Specialty directly to provider's office.

## 5) PRESCRIPTION INFORMATION

| Medication                | Strength         | Directions                                                  | Quantity    | Refills       |
|---------------------------|------------------|-------------------------------------------------------------|-------------|---------------|
| Viltepso<br>(Viltolarsen) | 250mg/5mL<br>SDV | Infuse 80mg/kg IV once weekly over approximately 60 minutes | _____ vials | Refills: ____ |
|                           |                  | Other: _____                                                | _____ vials | Refills: ____ |

## 6) Complete below if Home Infusion or Coram AIS administration

|                                                        |                                                                                                    |
|--------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| <b>Catheter</b>                                        | <b>Catheter Care</b> – flush only on drug admin days – SASH or PRN to maintain IV access & patency |
| <input type="checkbox"/> PIV (default if no selection) | <b>PIV</b> – NS 5ml (Heparin 10 units/ml 3-5ml if multiple days)                                   |
| <input type="checkbox"/> Port                          | <b>Port</b> – NS 10mL & Heparin 100 units/ml 3-5ml                                                 |
| <input type="checkbox"/> PICC: # Lumens _____          | <b>PICC</b> – NS 10ml & Heparin 100 units/ml 3-5ml + Maintenance flushes per lumen                 |
| <input type="checkbox"/> Other: _____                  |                                                                                                    |

\*Give as PIV if Port/PICC failure

**For medications infused by a pump, gravity infusion should be used as backup in event of pump failure.**

**PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)**

|                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|
| <p>"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute</p> <p>Prescriber's Signature: _____ Date: _____</p>                                                                                                                                                                                         | <p>May Substitute / Product Selection Permitted / Substitution Permissible</p> <p>Prescriber's Signature: _____ Date: _____</p> |
| <p>Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber. This form is not a valid prescription in Arizona.</p> |                                                                                                                                 |

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

# Viltepso Prescription Order/Nursing

## Please Complete Patient and Prescriber Information

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_ Patient Phone: \_\_\_\_\_  
 Patient Address: \_\_\_\_\_  
 Prescriber Name: \_\_\_\_\_ Prescriber Phone: \_\_\_\_\_

### 7) PREMEDICATIONS (Home Infusion or Coram AIS administration)

|                                |                                                                |                             |                                        |
|--------------------------------|----------------------------------------------------------------|-----------------------------|----------------------------------------|
| Diphenhydramine oral<br>25mg   | <input type="checkbox"/> 25mg PO 30 minutes prior to infusion  | Quantity: 1<br>per infusion | Refills to match prescription(s) above |
|                                | <input type="checkbox"/> 50mg PO 30 minutes prior to infusion  | Quantity: 2<br>per infusion | Refills to match prescription(s) above |
| Acetaminophen<br>325mg tablets | <input type="checkbox"/> 325mg PO 30 minutes prior to infusion | Quantity: 1<br>per infusion | Refills to match prescription(s) above |
|                                | <input type="checkbox"/> 650mg PO 30 minutes prior to infusion | Quantity: 2<br>per infusion | Refills to match prescription(s) above |
| Medication:                    | <input type="checkbox"/> Directions:                           | Quantity: ____              | Refills to match prescription(s) above |
| Medication:                    | <input type="checkbox"/> Directions:                           | Quantity: ____              | Refills to match prescription(s) above |
| Medication:                    | <input type="checkbox"/> Directions:                           | Quantity: ____              | Refills to match prescription(s) above |

### 8a) Acute Infusion Reaction Medications – Home Infusion

Please fill out below if going to be infused at HOME and patient requires any other medication besides Epinephrine:

|                                                                                                                        |                                                                                  |                                                                                 |                                        |       |
|------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|---------------------------------------------------------------------------------|----------------------------------------|-------|
| Epinephrine Autoinjector or Ampule ( <b>REQUIRED</b> )                                                                 | Adult 0.3mg (>30kg / >66lbs)                                                     | Administer IM PRN severe allergic reaction.<br>Call 911-may repeat in 5-15 min. | Quantity: 2                            | RF: 0 |
|                                                                                                                        | Pediatric 0.15mg (>15-30 kg/ >33-66 lbs)                                         |                                                                                 | Quantity: 2                            | RF: 0 |
|                                                                                                                        | *Infant 0.01mg/kg (<15 kg / <16.5 lbs)<br><i>*not available in auto-injector</i> |                                                                                 | Quantity: 2                            | RF: 0 |
| *Pharmacy to determine dose based on patient weight (above). Leave on file if patient has in-date epinephrine on hand* |                                                                                  |                                                                                 |                                        |       |
| Medication:                                                                                                            | <input type="checkbox"/> Directions:                                             | Quantity: ____                                                                  | Refills to match prescription(s) above |       |
| Medication:                                                                                                            | <input type="checkbox"/> Directions:                                             | Quantity: ____                                                                  | Refills to match prescription(s) above |       |

### 8b) Acute Infusion Reaction Medications – Coram AIS (Coram AIS will provide drug and supplies for the below if MD prescribes)

Please fill out below if going to be infused at CORAM and patient requires any other medication besides Epinephrine:

|                                                               |                                                                                                     |                                         |
|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|-----------------------------------------|
| Epinephrine 1mg/ml amp (1:1000)                               | Adult (>30kg): 0.3mg IM PRN severe allergic reaction. Call 911. May repeat in 5-15 minutes          | Refills to match prescriptions(s) above |
| Epinephrine 1mg/ml amp (1:1000)                               | Pediatric (>15-30 kg): 0.15mg IM PRN severe allergic reaction. Call 911. May repeat in 5-15 minutes | Refills to match prescriptions(s) above |
| Epinephrine 1mg/ml amp (1:1000)                               | Infant (<15 kg): 0.01mg/kg IM PRN severe allergic reaction. Call 911. May repeat in 5-15 minutes    | Refills to match prescriptions(s) above |
| *CORAM AIS to determine dose based on patient weight (above)* |                                                                                                     |                                         |
| Diphenhydramine 50mg/1ml vial                                 | Directions:                                                                                         | Refills to match prescription(s) above  |
| Diphenhydramine oral Liquid 12.5mg/5ml                        | Directions:                                                                                         | Refills to match prescription(s) above  |
| Acetaminophen oral                                            | Directions:                                                                                         | Refills to match prescription(s) above  |
| Methylprednisolone univial (adult) 125mg                      | Directions:                                                                                         | Refills to match prescription(s) above  |
| Methylprednisolone univial (pediatric) 40mg                   | Directions:                                                                                         | Refills to match prescription(s) above  |
| NaCl 0.9% 10ml PFS                                            | Directions:                                                                                         | Refills to match prescription(s) above  |
| 500ml NS with rate flow admin set                             | Directions:                                                                                         | Refills to match prescription(s) above  |
| Hydrocortisone univial (adult) 250mg                          | Directions:                                                                                         | Refills to match prescription(s) above  |
| Hydrocortisone univial (pediatric) 100mg                      | Directions:                                                                                         | Refills to match prescription(s) above  |

### PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

|                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|
| “Dispense As Written” / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute<br>Prescriber’s Signature: _____ Date: _____                                                                                                                                                                                             | May Substitute / Product Selection Permitted / Substitution Permissible<br>Prescriber’s Signature: _____ Date: _____ |
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Patient Address: \_\_\_\_\_  
Prescriber Name: \_\_\_\_\_ Prescriber Phone: \_\_\_\_\_

### Preparation and Administration

- Prior to administration, verify AIR medications are available at the site of infusion.
- Oral- Validate that premedications have been taken prior to preparing the medication.
- Injectable- Validate all injectable premedications are available and ready to administer prior to preparing the medication.
- Do not begin preparation until IV access has been established and or patency confirmed.
- Inspect product for any particulate matter/discoloration prior to administration
- Allow vials to warm to room temperature
- Mix contents of each vial by gently inverting 2-3 times – Do not shake
- Withdraw the calculated volume of drug from the appropriate number of vials
- If total volume of Viltepso is less than 100ml, dilution in 0.9% NaCl is required:
  - Withdraw from the 100ml infusion bag a volume of 0.9% NaCl equal to the calculated volume of Viltepso and inject the Viltepso into the infusion bag so the total volume in the bag is 100ml
- If required volume of Viltepso is 100ml or more, dilution is not required and required amount of Viltepso should be placed into an empty infusion bag
- Gently invert the infusion bag to ensure equal distribution of product – do not shake
- Infusion should begin as soon as possible, but no more than 5 hours after preparation of Viltepso and should be completed within 6 hours of preparation (allowing for 1 hour infusion time) if diluted solution is stored at 68-79°F
- Flush the IV access line with 0.9% NaCl after infusion

Rx includes related diluents, pumps, DME, ancillary supplies (e.g., needles, syringes, dressings) as necessary for drug administration/catheter maintenance and nursing services for drug administration/therapy teach train or catheter maintenance.

Additional Notes: \_\_\_\_\_

MD Agent/Title Issuing Order \_\_\_\_\_

Date & Time \_\_\_\_\_

RPh Name Receiving Verbal Order \_\_\_\_\_

Verify Read Back – Initials \_\_\_\_\_

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### 6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

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No Substitution / DAW / May Not Substitute

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

May Substitute / Product Selection Permitted / Substitution  
Permissible

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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