



Viltepso Prescription Order/Nursing Order

Fax Referral To: 1-855-297-1270

Address: 6020 Roberto Sanchez Villella Ave Carolina, PR 00982

Phone: 1-888-280-1190

NCPDP: 4026325

1) PATIENT INFORMATION

First Name:	Last Name:	DOB:	Gender:	CVS Account #:
Address:		City:	State:	ZIP:
Phone:	Allergies:	Weight:		ICD-10:
☐ Start of treatment	☐ 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? ☐ Yes ☐ No	Is this patient enrolled or eligible for Medicare/Medicaid? ☐ Yes ☐ 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#:
☐ Check box if patient is enrolled in manufacturer copay assistance,		If yes, please provide ID#	

4) SERVICE LOCATION

☐ Home Infusion	☐ Coram AIS	(Drug, Diluents, Supplies, and Nursing for drug administration or catheter maintenance)	
☐ MD Office	☐ 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 (Viltolarsen)	250mg/5mL 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

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

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute Prescriber's Signature: _____ Date: _____	May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature: _____ Date: _____
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.	

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.

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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 25mg	☐ 25mg PO 30 minutes prior to infusion	Quantity: 1 per infusion	Refills to match prescription(s) above
	☐ 50mg PO 30 minutes prior to infusion	Quantity: 2 per infusion	Refills to match prescription(s) above
Acetaminophen 325mg tablets	☐ 325mg PO 30 minutes prior to infusion	Quantity: 1 per infusion	Refills to match prescription(s) above
	☐ 650mg PO 30 minutes prior to infusion	Quantity: 2 per infusion	Refills to match prescription(s) above
Medication:	☐ Directions:	Quantity: ____	Refills to match prescription(s) above
Medication:	☐ Directions:	Quantity: ____	Refills to match prescription(s) above
Medication:	☐ 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 (REQUIRED)	Adult 0.3mg (>30kg / >66lbs)	Administer IM PRN severe allergic reaction. 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) <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:	☐ Directions:	Quantity: ____	Refills to match prescription(s) above	
Medication:	☐ 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

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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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