NS Support
NS PHARMA ACCESS SOLUTIONS

Prescription Form for VILTEPSO® (viltolarsen)

Before completing the Prescription Form for VILTEPSO:

- **Complete and submit a Patient Start Form** to NS Support for each patient. This Prescription Form is not a substitute for the **Patient Start Form**, which is available at www.viltepso.com/support
- **Confirm prescription requirements** with the patient's health plan and infusion provider
- **Questions?** Connect with NS Support at 833-NSSUPRT (833-677-8778), Monday-Friday, 8 AM-8 PM ET

PHYSICIAN INFORMATION

NAME (First, Last) _____ FACILITY NAME _____

ADDRESS _____ SUITE # _____ CITY _____ STATE _____ ZIP _____

NPI # _____ OFFICE CONTACT _____

PHONE _____ FAX _____

PRESCRIPTION FOR VILTEPSO INJECTION, FOR IV INFUSION

PATIENT NAME (First, MI, Last) _____ DOB (MM/DD/YYYY) _____ WEIGHT (kg) _____

Treatment Regimen

DOSAGE FORM AND STRENGTH: VILTEPSO 250 mg/5 mL (50 mg/mL) in a single-dose vial.

PRESCRIBING INSTRUCTIONS: Administer VILTEPSO 80 mg/kg intravenously, once a week, over 60 minutes. Combine with normal saline to a minimum volume of 100 mL. No dilution is needed if the drug volume is over 100 mL.

MEDICATION	ROUTE	DOSE	DIRECTIONS	DAYS SUPPLY	REFILLS
VILTEPSO	☒ IV	80 mg/kg	_____ mg every week (Supplied as 250 mg/5 mL vials)	❑ 28 (4 weeks or 4 doses) ❑ Other (specify) _____	❑ 1 year ❑ Other (specify) _____

Important Confidentiality Notice: This prescription and any documents accompanying it may contain information that is privileged or confidential and/or may contain protected health information (PHI). We are required to safeguard PHI by applicable law. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, please note that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you are not the intended recipient, please notify the sender immediately and arrange for the return or destruction of these documents.

PRESCRIBER INFORMATION (REQUIRED) SPECIAL NOTE: Physician must comply with state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in follow-up and delayed processing. Prescription is valid for 1 year after physician signature.

DIAGNOSIS: G71.01 Duchenne muscular dystrophy

PRESCRIBER SIGNATURE REQUIRED TO VALIDATE PRESCRIPTION (NO STAMPS ALLOWED): I certify that treatment with VILTEPSO is medically necessary for this patient. I have reviewed the current VILTEPSO Prescribing Information and I will be supervising the patient's treatment.

PRESCRIBER NAME (Please Print) _____

PRESCRIBER SIGNATURE (Dispense as written) _____ DATE _____

(Prescriber's signature required. Stamped signature not allowed.)

For more information about VILTEPSO, visit www.VILTEPSO.com and see full Prescribing Information.

NS Pharma