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Onpattro (patisiran)

Provider Order Form rev. 5/20/2022

PATIENT INFORMATION

Patient Name: DOB:

Patient Phone: Patient Email:

NKDA Allergies: Weight lbs/kg: Height:

Patient Status: New to Therapy Continuing Therapy Therapy Change Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

DOCUMENTATION (REQUIRED)

Labs Insurance Card (front and back) Current Medications History/Progress Notes

ICD-10 CODE

E85.1 Polyneuropathy of hereditary transthyretin-mediated amyloidosis

Other: ______________________________

PRE-MEDICATION ORDERS (give 60 minutes prior to infusion)

Standard Order

methylprednisolone (Solu-Medrol) 125mg IV

acetaminophen (Tylenol) 500mg 650mg 1000mg PO

diphenhydramine (Benadryl) 50mg IV

ranitidine (Zantac) 50mg IV

ADDITIONAL PRE-MEDICATION ORDERS

ibuprofen 400mg PO

cetirizine (Zyrtec) 10mg PO

loratadine (Claritin) 10mg PO

Other: ____

Dose: _________ Route: _____ Frequency: ________________________

MEDICATION ORDER

Onpattro (patisiran)

Dose:

0.3mg/kg IV

30mg IV

Frequency

every 3 weeks

Order Expiration Date (mm/dd/yy): ___________________
(If not indicated order will expire one year from date signature)

SPECIAL INSTRUCTIONS

Provider Name (Print) **Provider Signature** **Date**

Check here if this is a stat order