aleracare
advanced infusion centers™

FAX 833.329.4738

Onpattro (patisiran)

Provider Order Form rev. 5/5/2023

Patient Information

Patient Name: DOB:

Patient Phone: Patient Email:

◯ NKDA ◯ Allergies: Weight lbs/kg: Height:

Patient Status: ◯ New to Therapy ◯ Continuing Therapy ◯ Therapy Change Last infusion date (if applicable): _____

Is the patient pregnant, planning a pregnancy or nursing: ◯ Yes ◯ No Does the patient need interpreter services: ◯ Yes ◯ No

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

ICD-10 CODE

◯ E85.1 Polyneuropathy of hereditary transthyretin-mediated amyloidosis ◯ Other: _____

Medication Order

Onpattro (patisiran) **Dose:** ◯ 0.3mg/kg IV ◯ 30mg IV **Frequency:** ◯ every 3 weeks

Documentation Required (Note: Send all labs, must include specific labs listed here)

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

Pre-Medication Order

Standard Order *(give 60 minutes before each infusion):*

◯ **methylprednisolone** (Solu-Medrol) ◯ 125mg IV ◯ **diphenhydramine** (Benadryl) ◯ 50mg IV

◯ **acetaminophen** (Tylenol) ◯ 500mg ◯ 650mg ◯ 1000mg PO ◯ **ranitidine** (Zantac) ◯ 50mg IV

Additional Pre-Medication Order

◯ **ibuprofen** ◯ 400mg PO ◯ **loratadine** (Claritin) ◯ 10mg PO

◯ **cetirizine** (Zyrtec) ◯ 10mg PO ◯ **other:** _____

Dose: _____ Route: _____ Frequency: _____

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

Provider Name **Provider Signature** **Date**

Order Expiration Date (mm/dd/yy): _____ (If not indicated order will expire one year from date signature) Check here if this is a stat order ◯