aleracare
advanced home infusion

FAX 818.390.9697

Onpattro (patisiran)

Provider Order Form rev. 10/8/2024

Patient Information

Patient Name: DOB:

Patient Home Phone: Patient Cell Phone: Patient Email:

Emergency/Alternate Contact Name: Emergency/Alternate Contact Phone:

◯ 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 (___mg) IV ◯ 30mg IV **Frequency:** ◯ every 3 weeks Qty: 1 dose

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: _____

Line/Port Use Orders

RN to start/discontinue peripheral IV or access/de-access port

◯ RN to administer 3-10 mL normal saline with heparin 100 units/mL 1-5 mL per SASH method

◯ Do NOT administer heparin to this patient

◯ Additional orders: _____

Adverse Reaction and Anaphylaxis Orders

◯ Standard anaphylaxis kit (epinephrine 0.3 mg IM PRN for severe reactions x 1, may repeat once within 5-15 minutes for a maximum of 2 doses; Benadryl 50 mg PO PRN for mild-moderate reactions x1; Benadryl 50 mg IV PRN for mild-moderate reactions x1)

◯ Additional orders: _____

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

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

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

Check here if this is a stat order ◯