aleracare
advanced home infusion

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Onpattro (patisiran)

Provider Order Form rev. 10/24/2024

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 **Frequency:** every 3 weeks Qty: 1 dose

30mg IV

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

famotidine 20mg IV 40mg 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