Onpattro

Provider Order Form

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):

REQUIRED DOCUMENTATION

◯ Labs (Hep B and Serum Immunolobulins) ◯ Insurance Card (front and back) ◯ Current Medications ◯ History/Progress Notes

ICD-10 CODE

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

PRE-MEDICATION ORDER

◯ **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: ________________

MEDICATION ORDER

Onpattro (patisiran)

Dose:
◯ 0.3mg/kg IV
◯ 30mg IV

Frequency:
◯ every 3 weeks

PROVIDER INFORMATION

Provider Name: Provider Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

SPECIAL INSTRUCTIONS

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Provider Name **Provider Signature** **Date** ◯ **Check here if this is a stat order**

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