medix infusion

Onpattro Order Form
(patisiran)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M / F Ht: _____ Wt: _____ lbs / kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code

☐ E85.1 Neuropathic Heredofamilial Amyloidosis

Other: _____

Prescribing Information

Supplementation at the recommended daily allowance of vitamin A is advised for patients taking Onpattro.

If a dose is missed, administer as soon as possible:

- within 3 days of the missed dose, keep patient's original schedule.

- more than 3 days after missed dose, schedule the next appointment **3 weeks later.**

REQUIRED: **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

LAB RESULTS: **Serum TTR, PND Scores, FAP Stage, or modified Neuropathy Impairment Scores and/or tests to support diagnosis.**

PRESCRIPTION

Pre-Medications

PRE-MEDS MUST BE GIVEN 60 MINUTES PRIOR TO INFUSION.

Acetaminophen: 500 mg PO
Dexamethasone: 10 mg SIVP x1
Diphenhydramine: 50 mg IVP
Famotidine: 20 mg IVP
Other: _____

Onpattro (patisiran)

Infuse in 0.9% Sodium Chloride for a total volume of 200 mL via pump with DEHP-free infusion set containing 1.2-micron filter as per ramping protocol. Prepared using 0.45-micron (PES) syringe filter and line that are DEHP-free.

Dose: **(SELECT ONE)**

IV: (wt < 100 kg): Infuse 0.3 mg/kg every 3 weeks for one year
IV: (wt ≥ 100 kg): Infuse 30 mg every 3 weeks for one year

Patient Weight: _____ lbs **or** _____ kg

In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

Post Treatment Observations: The patient is observed for 30 minutes following the first infusion.

Comments: _____

_____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ ***Signature:*** _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip:_____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____