medix infusion

Onpattro Order Form
(patisiran)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____

DOB: _____ Phone: _____ Sex: ☐ M ☐ F

DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (Required)

☐ E85.1 Polyneuropathy of hereditary transthyretin-mediated amyloidosis

☐ Other:

_____

Patient Status:

☐ New to therapy

☐ Continuing therapy (date of last dose _____)

Medix Infusion will adhere to the following prescribing information:

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

Weight: _____ ☐ lb ☐ kg Height: _____

Allergies: _____

PRESCRIPTION

Pre-Medications (Required)

- Acetaminophen: 500mg PO
- Dexamethasone: 10mg SIVP x 1
- Diphenhydramine: 50 mg IVP
- Famotidine: 20 mg IVP

☐ Other: _____

ONPATTRO (patisiran)

Wt < 100kg: Infuse 0.3 mg/kg IV eery 3 weeks for one year
Wt ≥ 100kg: Infuse 30 mg IV every 3 weeks for one year

Is the patient on any other disease modifying therapy? ☐ **Yes** ☐ **No**

Is yes, please note therapy and last dose: _____

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

Other Orders: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- Signed and completed order
- Patient's demographic and insurance information
- Patient's medication list
- Supporting clinical notes that include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

Supporting/labs diagnostics:

- Serum TTR
- PND Scores
- FAB Stage or modified Neuropathy Impairment scores and/or tests to support diagnosis

Medix Infusion will collect all necessary labs if not included in referral documents

PRESCRIBER INFORMATION

Prescriber Name: _____

Signature: _____

NPI #: _____ Date: _____

Supervising Physician (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____