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 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

Loading 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

Is the patient on any other disease modifying therapy? ☐ **Yes** ☐ **No**
If yes, please note therapy and last dose: _____

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

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

Comments:

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

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