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: _____

Diagnosis

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

Medication Order

Pre-Medications (Required)

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

Is patient receiving a Vitamin A Supplement?

☐ Yes ☐ No

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

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

Comments: _____

Required Clinical Documentation

- **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**

LAB RESULTS:

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

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

If yes, please note therapy and last dose:

_____

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

Referring Provider Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in deaing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____ Date: _____

Prescriber Name: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

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