

ONPATTRO (patisiran)INFUSION ORDERS

PATIENT	INFORMATION	N _	Demographic	s attached		
Patient Name:	DOB:		Phone:			
INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S), FRONT AND BACK						
MEDICAL INFORMATION						
Diagnosis: Polyneuropathy of hereditary transthyretin mediated amyloidosis (ICD-10 Code:)						
Patient Weight: lbs. Allergies:						
Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached						
Patient has been advised to take Vitamin A supplementation						
Labs: Required labs to be drawn by: 🔲 Infusion Clinic 🔲 Referring Physician						
Lab Orders:						
ONPATTRO ORDERS						
Less than 100 kg		Greater than 100 kg				
0.3 mg/kg IV every 3 weeks	∐ 30	30 mg IV every 3 weeks				
Protocol Pre-medications to be given 1 hour prior to Solu-medrol 125 mg IV, Tylenol 500 mg PO, E Other: Additional Orders/Comments:	Benadryl 50 mg		20 mg IV			
, reductional orders, comments.						
**Once we receive all necessary documentation, we will schedule the patient's treatment.						
PHYSICIAI	N INFORMATIO	N				
By signing this form and utilizing our services, you are auth prior authorization and specialty pharmacy designated ag				-	I	
Physician Signature:			Date:			
Physician Name:						
Phone: Fax:	Contact Persor					
INFUSION CENTER LOCATION						
□ Arlington □ Austin □ Dallas □ Houston □ Knoxvill P: 817.200.2530 P: 512.261.4800 P: 972.408.2777 P: 713.860.1755 P: 865-299-7 F: 817.509.0011 F: 512.261.4803 F: 469.913.6894 F: 713.277.7219 F: 865-338-5	525 P: 817.284.2700	Plano P: 469-974-0565 F: 469-608-2072	Round Rock P: 737-443-5230 F: 737-402-7698	San Antonio P: 210.366.4358 F: 210.366.4896	Stone Oak P: 210.485.3700 F: 210.390.1738	

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