Patisiran (Onpattro)

Provider Order Form rev. 1/20/2022

www.aleracaremedicalgroup.com
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PATIENT INFORMATION

Patient Name: DOB:

☐ NKDA Allergies: Weight lbs/kg:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

ICD-10 CODE

☐ E85.1 Neuropathic heredofamilial amyloidosis

☐ Other ______________________

MEDICATION ORDER

☑ **Patisiran** (Onpattro) intravenous infusion

- Dose: 0.3mg/kg (For patients weighing less than 100kg) / 30mg (For patients weighing more than 100kg)
- Frequency: ☐ every 3 weeks / ☐ other: _______________
- Dilute the required volume into an infusion bag containing 0.9% Sodium Chloride for a total volume of 200ml
- Infuse over 80 minutes (60ml/hr x 15 minutes, then increase to 180ml/hr for the remainder of the infusion)

☑ Flush with 0.9% sodium chloride at the completion of infusion

☐ Patient is required to stay for 30-minute observation period

☐ Patient is NOT required to stay for observation time

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ ______________________

(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

Provider Name (Print) **Provider Signature** **Date**

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication ☐ History and Physical Report

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months