Local Infusion

MYLOCALINFUSION.COM

ONPATTRO (PATISIRAN) ORDER FORM

PATIENT INFORMATION

Patient Name: ______________________ DOB: __________

Mobile Number: ______________ Patient Weight: ______________

Allergies: ______________________

DIAGNOSIS (Provider must specify)

❑ Neuropathic heredofamilial amyloidosis, ICD 10: E85.1

❑ Other: ______________________

PROVIDER INFORMATION

Provider Name (print name): ______________ Provider NPI: __________

Signature: ______________________ Date: __________

Contact Name: ______________ Phone: __________ Fax: __________

Email Address: ______________________

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO

❑ Benadryl 25mg PO

❑ Famotidine 20 mg IV

❑ Cetirizine (Zyrtec) 10 mg PO

❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Other: ______________ Dose: __________ Route: __________

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Onpattro	❑ 0.3 mg/kg (for pt weight less than 100kg) ❑ 30 mg (for pt weight 100 kg or more)	❑ IV	❑ Every 3 weeks

❑ New Start Therapy ❑ Continuation of Therapy Date of last dose (if applicable): __________

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: ❑ NH: 603.217.5371 ❑ ME: 207.407.7272

Order valid for 1 year from date of signature unless otherwise specified here: __________