

## ONPATTRO (PATISIRAN) ORDER FORM

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Mobile Number: \_\_\_\_\_ Patient Weight: \_\_\_\_\_

Allergies: \_\_\_\_\_

### DIAGNOSIS (Provider must specify)

Neuropathic hereditary 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

Famotidine 20 mg IV

Methylprednisolone (Solu-Medrol) 125 mg IVP

Benadryl 25mg PO

Cetirizine (Zyrtec) 10 mg PO

Other: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

### MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Onpattro	<input type="checkbox"/> 0.3 mg/kg (for pt weight less than 100kg) <input type="checkbox"/> 30 mg (for pt weight 100 kg or more)	<input type="checkbox"/> IV	<input type="checkbox"/> Every 3 weeks

New Start Therapy     Continuation of Therapy    Date of last dose (if applicable): \_\_\_\_\_

### LABS / SPECIAL INSTRUCTIONS

**FAX NUMBERS:**  CT: 203.433.0621     ME: 207.407.7272     NH: 603.217.5371     NJ: 201.581.4521

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