Patisiran (Onpattro)

Provider Order Form rev. 10/30/2023

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults:

Other: Description:

THERAPY ADMINISTRATION & DOSING *(Choose one)*

☐ Weight less than 100kg: Administer Onpattro 0.3mg/kg x __________ kg= ________ mg IV every 3 weeks

☐ Weight greater than or equal to 100kg: Administer Onpattro 30mg IV every 3 weeks

ADDITIONAL ORDERS

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every: ________

☐ CMP ☐ at each dose ☐ every: ________

☐ CRP ☐ at each dose ☐ every: ________

☐ Other: _________________________________

PRE-MEDICATION ORDERS *(not optional, must administer one-time 60mins prior to infusion)*

☑ Required Pepcid 20mg IVP

☑ Required Tylenol 500mg PO

☑ Required Solumedrol 125mg IV

☑ Required Benadryl 50mg IV

☐ Other: _________________________________

NURSING

☑ Hold infusion and notify provider for:

- Signs/symptoms of infection.
- planned/recent surgical procedures.
- recent live vaccines
- new/worsening neurological or mood changes.

☑ Monitor vitals at start of infusion and every 30mins

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, neurological status, motor function, ambulatory status

Required Labs: TTP protein variants

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.