Local Infusion

MYLOCALINFUSION.COM

ONPATTRO (PATISIRAN) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____kg

Allergies: _____

❑ Patient has known difficult venous access. Comments: _____

❑ New Start Therapy | ❑ Continuation of Therapy & Date of last dose (if applicable): _____

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

Recommendations per PI are selected, these will be given to patient unless otherwise specified.

☑ Methylprednisolone (Solu-Medrol) 125mg IVP

☑ Benadryl 25mg PO

❑ Famotidine 20mg IV

☑ Acetaminophen (Tylenol) 500mg PO

❑ Cetirizine (Zyrtec) 10mg PO

❑ 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

LABS / SPECIAL INSTRUCTIONS