INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

# Onpattro *patisiran*

## 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) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

## PREREQUISITES TO TREATMENT

*Ensure the following is complete and attached with the referral*

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

## PRE-MEDICATION

*Recommendations per PI are pre-selected; these will be given unless otherwise specified.*

☑ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☑ Methylprednisolone (Solu-Medrol) 125 mg IVP

☑ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO

☐ Other _____ Dose _____ Route _____

## MEDICATION ORDER

| MEDICATION | DOSE | ROUTE | FREQUENCY |
|---|---|---|---|
| Onpattro | ☐ 0.3 mg/kg (for pt weight less than 100kg)<br>☐ 30 mg (for pt weight 100 kg or more) | IV | Every 3 weeks |

## LABS / SPECIAL INSTRUCTIONS

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