Onpattro
(patisiran)

Advanced Infusion Care Centers

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies ☐ See List ☐ NKDA City, State, Zip: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ in ☐ cm Email: _____

PRIMARY DIAGNOSIS

☐ Polyneuropathy of hereditary transthyretin-mediated amyloidosis (E85.1)

☐ Other: _____

PRESCRIPTION

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☐ <100 kg: Give 0.3 mg/kg IV every 3 weeks x 1 year

☐ >100 kg: Give 30 mg IV every 3 weeks x 1 year

☐ Other: _____

Has patient received any doses of this medication in the past? ☐ Yes ☐ No

☑ Refill x 12 months unless otherwise noted: _____

REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Patient Demographics
- Medication List
- Most recent labs
- Baseline PND Score
- MRI Results
- Documentation of gene TTR mutation
- Confirmed diagnosis of hATTR

ANCILLARY ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS

Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol
(See aiscaregroup.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PRE-MEDICATION ORDERS PROTOCOL

Per infusion center protocol: Solu-medrol 125 mg IV, Tylenol 650 mg PO, Benadryl 50 mg IV, Pepcid 20 mg IV 1 hour prior to infusion unless contraindicated.

☐ Provider Prescribed: _____

LINE CARE ORDERS

Start PIV/Access CVC

Flush device per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*

☐ Other Flush Orders: Please fax other line care orders if checking this box

LAB ORDERS—PLEASE INCLUDE FREQUENCY

☐ Please list any labs to be drawn by the infusion clinic: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.