immersiv HEALTH

ONPATTRO® ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

☐ E85.1 Neuropathic Heredofamilial amyloidosis

☐ ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

☐ Insurance Information

☐ List of Medications

☐ Tried & Failed Therapies

☐ Most Recent History & Physical

☐ PND Scores, Serum TTR, or FAP Stage

☐ Counseled on Vitamin A supplementation

MEDICATION ORDER

***For Patients Weighing < 100kg.**

☐ Onpattro® (patisiran) 0.3mg/kg IV in total volume 200ml NS over 80 minutes every 3 weeks

***For Patients Weighing ≥ 100kg.**

☐ Onpattro® (patisiran) 30mg IV in total volume 200ml NS over 80 minutes every 3 weeks

*Ensure use of 0.45m filter in drug prep and DEHP-free set for administration

☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

PRE-MEDICATIONS

REQUIRED

☑ Acetaminophen: 500 mg	☑ PO	☐ IV
☑ Dexamethasone: 10mg	☐ PO	☑ IV
☑ Diphenhydramine: 50 mg	☐ PO	☑ IV
☑ Famotidine: 20mg	☐ PO	☑ IV
OTHER: _____	☐ PO	☐ IV

Patient to be observed for 30 minutes following the first infusion.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ **CONTACT NAME:** _____
(IF APPLICABLE)

SIGNATURE: _____ _____ **DATE:** _____
(NO STAMPS)
SUBSTITUTION PERMITTED | DISPENSE AS WRITTEN