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. Administer per protocol.
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