

Los Angeles, CA
2080 Century Park East
Suite 710
Los Angeles, CA 90067



ONPATTRO (Patisiran) infusion orders

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order	

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: _____ Fax: _____
Practice Address:	City: _____ State: _____ Zip Code: _____

DIAGNOSIS *Please provide ICD-10 code*

_____ Multiple Sclerosis

_____ (other)

PRE-MEDICATION

IV corticosteroid (dexamethasone 10mg, or equivalent)

oral acetaminophen (500mg)

other at least 60 min. prior to admin

IV H1 Blocker (diphenhydramine 50mg or equivalent)

IV H2 Blocker (ranitidine 50mg or equivalent)

_____ (other)

_____ (other)

for premeds not available or not tolerated intravenously, equivalents may be administered orally

ONPATTRO ORDERS

PATIENT WEIGHT

_____ lbs.

_____ kg

DOSAGE:

0.3 mg/kg for patients < 100kg 30mg for patients ≥ 100kg

Other _____

Frequency every 3 weeks

Total dosage /refills _____

LABS

serum vitamin A

other _____

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____