TN
100 Covey Drive
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Franklin, TN 37067

Office: 212-803-3339 Fax : 646-768-8600

REJUVEINATE

ONPATTRO (Patisiran) infusion orders

Date: ___________

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS

☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ 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

- ☐ serium vitamin A
- ☐ other ____________

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** ______________________________________ Date ______________

Provider ______________________ Phone ___________ Fax ______________