

Chicago Illinois
4711 Golf Road
Suite 900
Skokie, IL 60076



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 _____