Vermont
28 Park Ave
Suite #1A
Williston, VT 05495

ThrIVewell™ INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

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 _____