

Westerville
575 Copeland Mill Road
Suite# 2F
Westerville, Ohio 43081



Lancaster
2405 Columbus Street
Suite# 210
Lancaster, Ohio 43130

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 <i>Please provide ICD-10 code</i> <input type="checkbox"/> _____ Multiple Sclerosis <input type="checkbox"/> _____ (other)	ONPATTRO ORDERS PATIENT WEIGHT _____ lbs. _____ kg DOSAGE: <input type="checkbox"/> 0.3 mg/kg for patients < 100kg <input type="checkbox"/> 30mg for patients ≥ 100kg <input type="checkbox"/> Other _____ <input type="checkbox"/> Frequency every 3 weeks <input type="checkbox"/> Total dosage <input type="checkbox"/> /refills _____ LABS <input type="checkbox"/> serum vitamin A <input type="checkbox"/> other _____
PRE-MEDICATION <input type="checkbox"/> IV corticosteroid (dexamethasone 10mg, or equivalent) <input type="checkbox"/> oral acetaminophen (500mg) <input type="checkbox"/> other at least 60 min. prior to admin <input type="checkbox"/> IV H1 Blocker (diphenhydramine 50mg or equivalent) <input type="checkbox"/> IV H2 Blocker (ranitidine 50mg or equivalent) <input type="checkbox"/> _____ (other) <input type="checkbox"/> _____ (other) for premeds not available or not tolerated intravenously, equivalents may be administered orally	

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X Date _____

Provider _____ Phone _____ Fax _____