Borough Park
1428 36th Street
Suite 107
Brooklyn, NY 11218

Forest Hills
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

NYC

E 56th & Park Midtown
120 East 56 Street
Suite 300
New York, NY 10022

E 70th St Upper East Side
225 E 70th Street
Suite 1E
New York, NY 10021

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

Mission Medical

Tarrytown
555 Taxter Road
3rd Floor
Elmsford, NY 10523

Southampton
625 Hampton Road
Southampton, NY 11968

Manhasset
333 East Shore Road
Suite 201
Manhasset, NY 11030

Sheepshead Bay
2546 East 17th Street
Fl, 1
Brooklyn, NY 11235

Long Island City
36-36 33rd
Suite 311
Long Island City, NY 11106

FIDI
30 Broad Street
Suite 401
New York, NY 10004

Central Park West
115 Central Park West
Suite 15
New York, NY 10023

Port Jefferson
12 Medical Drive
Suite B
Port Jefferson Station, NY 11776

Riverhead
1228 E Main Street
Suite A
Riverhead, NY 11901

Rockville Centre
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

Bronx
226 West 238th Street
Bronx, NY 10463

Massapequa
97 Grand Avenue
Massapequa, NY 11758

Gramercy
7 Gramercy Park West
Lower Level
New York, NY, 10003

Staten Island
27 New Dorp Lane
Staten Island, NY 10306

Holbrook
233 Union Avenue
Suite 207
Holbrook, NY 11741

New Hyde Park
1991 Marcus Ave
Suite 110
Lake Success, NY, 11042

Woodbury
7600 Jericho Tpke,
Lower Level, Suite C500
Woodbury NY 11797

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 _____