

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



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 <i>Please provide ICD-10 code</i> ☐ _____ Multiple Sclerosis ☐ _____ (other)	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 _____
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	

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____