ONPATTRO INFUSION ORDER
(Patisiran)

Date: ____/____/_____

PATIENT INFORMATION

Patient Name:_____ DOB:___/____/____ Phone: _____

Height: _____ Weight _____ lbs / kg

Allergies: _____

Diagnosis: _____ ICD-10: _____

hATTR Amyloidosis Lab Resullts:_____

Labs to be drawn by: O Infusion Clinic O Referring Physician

PRE-MEDICATIONS (60 MINUTES BEFORE)

Diphenhydramine:	O 50mg	O IV
Acetaminophen:	O 500mg	O PO
Famotidine:	O 20mg	O PO
Methylprednisolone:	O 40mg	O IV

ONPATTRO (PATISIRAN) ORDERS

O < 100kg, recommended dosage is 0.3mg/kg once every 3 weeks
O > 100kg, recommended dosage is 0.3mg once every 3 weeks
Next Dose Due:___/___/___

PROVIDER INFORMATION

Provider's Name: _____ Signature: _____

Phone: _____ Fax: _____ Date: _____/_____/_____

Office Address: _____

Email Address: _____ Contact Person: _____

PLEASE SEND COPY (FRONT AND BACK) OF INSURANCE CARD

PHONE: 972-810-0990 | FAX: 972-810-0994