Infusion ASSOCIATES®

Phone: (833) 394-0600 Fax: (833) 996-4888

Onpattro IV Infusion

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications and **Recent Visit Notes***

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

ICD-10 : _____, _____, _____

Does patient must have documented transthyretin (TTR) mutation (e.g., V30M) by genetic testing AND documented amyloid deposits in biopsy tissue? ☐ Yes, ***Please attach records*** ☐ No

Does patient have clinical signs and symptoms of the condition (e.g., motor disability, peripheral/autonomic neuropathy) ☐ Yes, ***Please attach records*** ☐ No

Is patient receiving Onpattro in combination with tafamidis (Vyndaqel, Vyndamax) or Tegsedi? ☐ Yes ☐ No

For continuation, has patient shown clinical benefit from Onpattro (e.g., improved neuropathy symptoms, slowing of disease progression)? ☐ Yes ☐ No

Labs to be collected: ☐ BMP ☐CBC w/o diff ☐ CMP ☐ _____

Lab Frequency: ☐ EVERY infusion ☐ Every OTHER infusion ☐ _____

REQUIRED pre-medications to be given within 60 mins of start of infusion:

Diphenhydramine IV	50 mg
Acetaminophen PO	650mg
Dexamethasone IV	10 mg
Famotidine IV	20 mg

Onpattro (patisiran) IV:
0.3 mg/kg
Dose:_____mg

max dose 30mg

Frequency: EVERY 3 weeks

Printed Provider Name: _____

Provider Signature: _____

Office Phone Number: _____**Office Fax Number:**_____

New referring providers, how did you hear about us? ☐Web Search ☐Pharma Rep ☐ Drug Locator ☐Patient ☐Word of Mouth ☐IA Clinical Liaison ☐IA Website ☐Facebook ☐Instagram ☐ Other: _____