Referral Status:		MRN:	
☐ New referral	☐ Order change	☐ Order Renewal	
Patient preferred clinic:			

ONPATTRO™ (patisiran) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:			
Patient Name:		Address:			
Date of Birth:		City, State, Zip:			
Height in inches:	Weight: LB or KG	Gender:	Allergies:	☐ See list	☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐ E85.1 - Neuropathic Heredofamilial amyloidosis

☐ _____ - Other:_____

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	Labs/Tests supporting primary diagnosis (serum TTR, PND Scores, FAP stage, or modified Neuropathy Impairment Scores)		☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive ONPATTRO™ if demonstrating signs and symptoms suggestive of **vitamin A deficiency.**

PREMEDICATION: To be administered 60 minutes prior to infusion as selected.

*FDA labeling suggests that all patients are premedicated with IV corticosteroid, acetaminophen 500mg PO, and both H1 and H2 antihistamine blocker IV 60 minutes prior to Infusion as per selected by referring physician below.

IV	Diphenhydramine	◯ 25mg	◯ 50mg						
	Methylprednisolone	◯ 40mg	◯ 125mg	◯ Other:					
	Famotidine	◯ 20mg	◯ 40mg						
	Dexamethasone	◯ 10mg	◯ Other:						
	Other:	◯							
PO	Acetaminophen	◯ 325mg	◯ 500mg	◯ 650mg	◯ 1000mg				
	Famotidine	◯ 20mg	◯ 40mg						
	Diphenhydramine	◯ 25mg	◯ 50mg						
	Fexofenadine	◯ 60mg	◯ 180mg						
	Cetirizine	◯ 10mg							
	Loratadine	◯ 10mg							
	Other:	◯							

MEDICATION:

☑ ONPATTRO™ (patisiran) in NS for a total volume of 200 ml IV via pump as per step protocol. **Utilizing infusion set and line that are DEHP-free.**

DOSE /FREQUENCY:

◯ <100kg: 0.3mg/kg IV every 3 weeks

◯ >100kg: 30mg IV every 3 weeks

◯ Other:_____

SPECIAL/LAB ORDERS:

◯ _____

_____

***If dose is received within 3 days of missed dose, then continue dosing according to original schedule. If greater than 3 days after missed dose, then continue dosing every 3 weeks thereafter.**

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion/AccuRX standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE:
Dispense as written/Brand medically necessary	Substitution permitted	

ACCURX
INFUSION CENTER
A PALMETTO INFUSION COMPANY

Checklist for referrals to AccuRX Infusion:

Fax referral to 1.866.990.3192

- ☐ **Patient demographics – address, phone number, SS#, etc.**
- ☐ **Insurance Information – copy of the card(s) if possible**
- ☐ **Plan of Treatment/Orders**
- ☐ **Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- ☐ **Any lab results or other diagnostic procedures to support the diagnosis**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with the patient and refer them to any available co-pay assistance as required. AccuRX Infusion Call Center 888.410.0317. Thank you for the referral.

www.AccuRXInfusion.com

02/08/2023