Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

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

ONPATTRO™ (patisiran) Standard Plan of Treatment

Rev 4.29.25

PATIENT DEMOGRAPHICS:

Patient Name:

Patient's Phone:		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:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	Labs/Tests supporting primary diagnosis (serum TTR, PND Scores, FAP stage, or modified Neuropathy Impairment Scores)

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO:	IF YES:
PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
	NEXT INFUSION DATE:

IF ORDER CHANGE:

☐ **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

Medication						
Diphenhydramine	☐	25mg	☐	50mg		
Methylprednisolone	☐	40mg	☐	125mg	☐	Other:
Famotidine	☐	20mg	☐	40mg		
Dexamethasone	☐	10mg	☐	Other:		
Other:	☐					

PO

Medication								
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. Infuse over approximately 80 minutes.
Utilizing infusion set and line that are DEHP-free.

SPECIAL/LAB ORDERS:

☐ ____

____

DOSE /FREQUENCY:

☐ < 100kg: 0.3mg/kg IV once every 3 weeks
☐ ≥ 100kg: 30mg IV once every 3 weeks
☐ Other:_________________________________

***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
☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

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

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	