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:		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. 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	

Palmetto INFUSION

Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- ☐ **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 patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.palmettoinfusion.com