Provider Order Form

ONPATTRO (PATISIRAN)

Uptiv Health

PATIENT

Full Name: _____ DOB: _____

Mobile Phone: _____ Weight: _____ ☐ lbs ☐ kg

Allergies: _____ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Neuropathic Heredofamilial Amyloidosis E85.1 ☐ Other: _____

PROVIDER

Provider Name: _____ Provider NPI: _____

Practice Name: _____ Referral Coordinator Name: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

PRE-MEDICATION

☒ Acetaminophen (Tylenol) PO	☒ 500 mg
☒ Diphenhydramine (Benadryl) ☐ PO ☒ IV	☒ 50 mg
☒ Methylprednisolone (Solu-Medrol) IV	☒ 125 mg
☒ Ranitidine (Zantac) IV	☒ 50 mg

☐ Other: _____

*Unless contraindicated, the above will be given with each infusion.

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☐ Onpattro (Patisiran), IV	☐ 0.3 mg/kg (for pt weight less than 100kg)	☐ Every 3 weeks
	☐ 30 mg (for pt weight 100 kg or more)	

Other: _____

Refills ☐ Zero ☐ 12 months ☐ _____. Order valid for 1 year unless otherwise stated. _____

☒ Infuse over at least 80 minutes.

☒ Flush with 0.9% sodium chloride at infusion completion.

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

☐ CBC	☐ at each dose	☐ every _____
☐ CMP	☐ at each dose	☐ every _____
☐ CRP	☐ at each dose	☐ every _____

☐ Other _____

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX

_____ _____

Provider Signature Date