Patisiran (Onpattro)

Provider Order Form *rev. 11/06/26*

arbor infusion

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Mobile Phone Number:

Weight (lbs/kg): ☐ NKDA Allergies:

Therapy Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

REQUIRED SUPPORTING DOCUMENTATION *(Please include the following with the order to support processing & insurance approval)*

• Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)

DIAGNOSIS ICD-10 CODE *(Provider must specify)*

☐ E85.1 Neuropathic Heredofamilial Amyloidosis

☐ Other:

PRIMARY MEDICATION ORDER

Patisiran (Onpattro) intravenous infusion

- Dilute the required volume into an infusion bag containing 0.9% Sodium Chloride for a total volume of 200ml
- Infuse over 80 minutes (60ml/hr x 15 minutes, then increase to 180ml/hr for the remainder of the infusion)
- Flush with 0.9% sodium chloride at infusion completion

☐ Patient is required to stay for 30-minute observation

• Refill for 12 months unless otherwise noted: _____

☐ **Weight <100kg:** Onpattro 0.3mg/kg IV every 3 weeks

☐ **Weight >100kg:** Onpattro 30mg IV every 3 weeks

SPECIAL INSTRUCTIONS

PRE-MEDICATION

Note: Recommendations per PI are selected, these will be given to patient unless otherwise specified.

☑ acetaminophen (Tylenol) ☑ 500mg / ☐ 650mg / ☐ 1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☑ famotidine (Pepcid) 20 mg IV

☑ diphenhydramine (Benadryl) ☐ 25mg / ☑ 50mg ☐ PO / ☑ IV

☑ dexamethasone (Decadron) 10mg IV

☐ Other: _____

Dose: _____ Route: _____

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ CRP ☐ at each dose ☐ every _____

☐ Other: _____

NURSING

- Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

Ordering Provider (Print) **Provider Signature** **Provider NPI** **Date**

☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zipcode:

ARBOR INFUSION FAX NUMBERS *(Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)*

☐ Arbor Infusion Fishers (317) 981-1772

☐ Arbor Infusion Carmel (317) 981-1772