

# Patisiran (Onpattro)

Provider Order Form rev. 8/23/26



## 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

## 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)

## SPECIAL INSTRUCTIONS

## 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](mailto:orders@arborinfusion.com))

☐ Arbor Infusion Fishers (317) 981-1772