

Patisiran (Onpattro)

Provider Order Form rev. 3/1/2023



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PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ DOB: _____

ICD-10 code (required): _____ ICD-10 description: _____

NKDA Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

NURSING

- Provide nursing care per 360 Infusion Center 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: _____

PRE-MEDICATION ORDERS* (REQUIRED)

- acetaminophen (Tylenol) 500mg PO
 diphenhydramine (Benadryl) 50mg IV
 ranitidine (Zantac) 50mg IV
 methylprednisolone (Solu-Medrol) 125mg IV

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

PRE-MEDICATION ORDERS (ADDITIONAL)

- ibuprofen (Advil) 400mg PO (If indicated, acetaminophen will be held)
 cetirizine (Zyrtec) 10mg PO
 loratadine (Claritin) 10mg PO
 Other: _____
Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

- Patisiran** (Onpattro) intravenous infusion
- Dose: 0.3mg/kg (For patients weighing less than 100kg) / 30mg (For patients weighing more than 100kg)
 - Frequency: every 3 weeks / other: _____
 - 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 period
 Refills: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

Provider Name (Print)

Provider Signature

Date