

Chicago Illinois
4711 Golf Road
Suite 900
Skokie, IL 60076



Date: _____

ONPATTRO (Patisiran) INFUSION orders

Patient Name _____ DOB _____

Phone _____

M ☐ F ☐
☐ Allergies

NPI _____ Tax ID _____

Insurance Carrier (primary) _____

REFERRAL STATUS

Insurance Carrier (secondary) _____

- ☐ New Prescription
- ☐ Order Renewal
- ☐ Does or Frequency Change
- ☐ Discontinuation

DIAGNOSIS please attest to ICD-10 code

- ☐ E 85.1 Neuropathic hereditary amyloidosis
- ☐ other _____

PRE-MEDICATION

- ☐ IV corticosteroid (dexamethasone 10mg, or equivalent)
- ☐ IV H1 Blocker (diphenhydramine 50mg or equivalent)
- ☐ oral acetaminophen (500mg)
- ☐ IV H2 Blocker (ranitidine 50mg or equivalent)
- ☐ other at least 60 min. prior to admin

for premeds not available or not tolerated intravenously, equivalents may be administered orally

ONPATTRO ORDERS

DOSAGE

0.3 mg/kg for patients < 100kg 30mg for patients ≥ 100kg

- ☐ other _____

Frequency every 3 weeks

PATIENT WEIGHT

_____ lbs

_____ kg

Notes

Total dosage ☐ /refills _____

LABS

- ☐ serum vitamin A
- ☐ other _____

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____