TN
100 Covey Drive
Suite 307
Franklin, TN 37067

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

REJUVEINATE

Date: _____

ONPATTRO (Patisiran) INFUSION orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

○ Allergies _____

NPI _____ Tax ID _____

Insurance Carrier (primary) _____

Insurance Carrier (secondary) _____

REFERRAL STATUS

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

DIAGNOSIS please attest to ICD-10 code

O E 85.1 Neuropathic heredofamilal amyloidosis
O other _____

PRE-MEDICATION

O IV corticosteroid (dexamethasone 10mg, or equivalent

O IV H1 Blocker (diphenhydramine 50mg or equivalent

O oral acetaminophen (500mg)

O IV H2 Blocker (ranitidine 50mg or equivalent

O 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
O other _____

Frequency every 3 weeks

PATIENT WEIGHT

_____ lbs

_____kg

Notes

Total dosage☐ /refills _____

LABS

O serium vitamin A
O other _____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____