MIC | METRO INFUSION CENTER

INFUSION ORDERS-ONPATTRO (PATISIRAN)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS		
☐ New Referral	☐ Dose or Frequency Change	☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

*List of infusion center locations may be found at: https://metroinfusioncenter.com/infusion-center-locations/
Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE	
☐ Neuropathic Hereditary Amyloidosis	ICD 10 Code: E85.1

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Clinical/Progress notes
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis

MEDICATION ORDERS	
Dosing	☐ Onpattro 0.3 mg/kg IV (Weight < 100kg) every 3 weeks ☐ Onpattro 30mg IV (Weight ≥ 100kg) every 3 weeks ☐ Other: Onpattro _____mg IV _____
Patient Weight = _____ kg	
Refills:	☐ X 6 months ☐ X 1 year ☐ _____ doses

PREMEDICATIONS
☐ Acetaminophen 650mg PO, 60 minutes prior to each Onpattro infusion
☐ Diphenhydramine 25mg PO, 60 minutes prior to each Onpattro infusion
☐ Methylprednisolone 100mg Slow IV Push, 60 minutes prior to each Onpattro infusion
☐ Famotidine 20mg IV push , 60 minutes prior to each Onpattro infusion
☐ Other: _____

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.
Contact us with questions at: (877) 448-3627
Fax Completed Form and all documentation to: 866-507-1164