# Onpattro® Referral Form

IVCareOptions

**PHONE: 1-800-277-7302 FAX: 1-866-374-6663**

**Demographics Information**: Today's Date _____

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: GA Zip: _____

Phone #: _____ ☐ Cell Alternate Phone #: _____ ☐ Cell

Height: _____ in/ft Weight: _____ lbs/kg Date weight recorded: _____ Last 4 of SSN#_____

Allergies: _____ ☐ **NKDA**

**Diagnosis Information**: ☐ Neuropathic heredofamilial amyloidosis E85.1

☐ Other Diagnosis/ICD10 code _____

Date Infusion to Begin: _____

Previous Infusion Reaction: ☐ YES ☐ NO

List Reactions: _____

Is this a first infusion? ☐ YES ☐ NO

Date of Last Infusion: _____

List of Failed Therapies: _____

**Assessment Questions**: *Please Provide Appropriate Documentation*

Diabetes? ☐ Yes ☐ No HTN? ☐ Yes ☐ No Cardiac History? ☐ Yes ☐ No Difficulty Breathing? ☐ Yes ☐ No

Requires Oxygen? ☐ Yes ☐ No Confusion /Disorientation? ☐ Yes ☐ No Neuro History? ☐ Yes ☐ No

Date of Negative TB test: _____ FAP stage _____ Baseline Polyneuropathy Disability score _____

**Onpattro (patisiran) J0222**

☐ **<100kg:** 0.3mg/kg IV every 21 days for _____ months

☐ **100kg or more:** 30mg IV every 21 days for _____ months

**Pre-Medications: Nurse to administer 60 minutes prior to infusion:** ☐ Dexamethasone 10mg IV x 1 dose

☐ Benadryl 50 mg IV x 1 dose

**Patient to provide and take 60 minutes prior to infusion**

☐ Acetaminophen 500 mg PO x1

☐ Other Pre-medication: _____

**Access**: ☐ **PIV** ☐ **PORT** ☐ **PICC** **Route:** ☐ **IV**

Catheter Care/Flush: To gain access, use for any ordered pre-medications, and/or PRN to maintain access and patency

PIV – NS 5ml: Qty 10

PORT – NS 10ml: Qty 10, Heparin 5mL 100units/mL x 1 per infusion.

PICC – NS 10ml: Qty 10, Heparin 5mL 10units/mL x 1 per infusion

**Supplies:** (please strike through if not required)

Administration Supplies (A4222) – 1 per infusion

Catheter Care Supplies (A4221) – 1 per week

Infusion Pump (E0781)

Nursing services to administer

***For insurance compliance, the prescribing physician or PA must sign, no stamps or nurse/NP signatures***

Physician/PA signature: _____

NPI # _____ Phone Number _____

Office Address: _____ City: _____ St ___Zip: _____

Printed Name:_____ Contact Name: _____

**Please fax this form to our Intake Department along with a copy of Patient's Insurance Card, Demographic information, H & P, Office Visit notes - including supporting documentation for failed therapies, and Up to Date Medication List.**

1/22 TSP