

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____
Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):
 Primary Diagnosis: _____ Neuropathic heredofamilial amyloidosis ICD-10 Code: E85.1 _____
 _____ Other: _____ ICD-10 Code: _____
 Allergies: _____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:
 • Clinical MD Notes, labs, test supporting primary diagnosis
 • Medication list
 ○ Patient has been advised regarding their need for Vitamin A supplementation

Patient Weight: _____ lbs. Patient Height: _____ in.

ONPATTRO® (patisiran) J Code: J0222

4. Drug Order:

Patient weight less than 100 kg (220 lbs):
 Administer Onpattro 0.3 mg/kg IV (_____ mg) every three weeks

Patient weight greater than 100 kg (220 lbs):
 Administer Onpattro 30 mg every three weeks

_____ # Refills (Recommend 8)

Pre-Medication Orders: Acetaminophen 500 mg PO, Diphenhydramine 50 mg IV, Dexamethasone 10 mg IV, and Famotidine 20 mg IV
 Administered 60 (sixty)minutes prior to infusion *Adjust to patient's needs

Other: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
 Dispense as written Substitution permitted
 Printed Physician's Name: _____ Contact Phone #: _____

FAX ALL INFORMATION CENTRAL FAX 803.999.1754 ALTERNATE FAX 803.999.1887	INFUSION CENTER LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 803.999.1960
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