Onpattro® Referral Form

PHONE: 1-800-277-7302 FAX: 1-866-374-6663 Email: intake@healthcoga.com ☐ ***Initial Order*** ☐ ***Reorder***

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 ☐

Neuro History? ☐ Yes ☐ No

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

Patient to Provide and take 30 minutes prior to infusion.

☐Acetaminophen 500mg PO x 1

Nurse to administer via IV 30 min prior: ☐ Benadryl 50mg IV X 1 ☐ Famotidine 20mg IV x 1

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 medications.

Administer the anaphylaxis protocol for adverse reactions.

Provider Signature: _____

NPI # _____ Phone _____ Fax _____

Office Address: _____ City: _____ St ___Zip: _____

Printed MD Name: _____ Contact Name: _____

☐ Demographic information ☐ Patient Ins. Card ☐ H & P ☐ Office notes ☐ Failed therapies in documentation

☐ Up to date medication list

9/23 TSP