Onpattro

INFUSION FOR HEALTH
InfusionForHealth.com
Ph: 888-777-1945 | Fax: 805-852-2636

Date: _____ Treatment Location: _____

PROVIDERS: Please include the following to expedite the order. Demographics, Insurance Information, H&P Relevant to the Diagnosis, Current Medications, hATTR Amyloidosis labs, Vitamin A level

PATIENT INFORMATION

Patient Name: _____

Patient Contact Number: _____

DOB: _____

Allergies: _____

Weight: _____ ○ lbs / ○ kg Height: _____

Diagnosis: ☐ Neuropathic Heredofamilial Amyloidosis ☐ E85.82

Other Dx/ICD10: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

PRE-MEDICATIONS:

(60 minutes prior)

Diphenhydramine:	☐ 50mg	IV	Acetaminophen:	☐ 500mg	PO
Famotidine:	☐ 20mg	PO	Dexamethasone:	☐ 10mg	IV

Center will use Hypersensitivity protocol established by Infusion for Health and P.I.

ONPATTRO DOSAGE

Date of Last Treatment, if Continuation: _____

☐ < 100 kg, recommended dosage is 0.3 mg/kg once every 3 weeks

☐ ≥ 100 kg, recommended dosage is 0.3 mg once every 3 weeks

Next Dose Due: _____ Route: ☑ IV

To ensure that a brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, Infusion for Health is authorized to administer generic or biosimilar.

Lab Orders: ☐ List: _____

☐ Prior to first appointment ☐ Other Frequency: _____

☐ Please check this box if you **DO NOT** authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

☐ Please check this box if you **DO NOT** authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.