Patisiran (Onpattro)

Provider Order Form rev. 3/25/2022

IVX HEALTH

PATIENT INFORMATION

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight lbs/kg:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 09.07.2021)

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

PRE-MEDICATION ORDERS* (REQUIRED)

☑ acetaminophen (Tylenol) 500mg PO
☑ diphenhydramine (Benadryl) 50mg IV
☑ ranitidine (Zantac) 50mg IV
☑ methylprednisolone (Solu-Medrol) 125mg IV

*Unless contraindicated, the above will be given with each infusion.

PRE-MEDICATION ORDERS (ADDITIONAL)

☐ ibuprofen (Advil) 400mg PO (If indicated, acetaminophen will be held)
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

☑ **Patisiran** (Onpattro) intravenous infusion
- Dose: 0.3mg/kg (For patients weighing less than 100kg) / 30mg (For patients weighing more than 100kg)
- Frequency: ☐ every 3 weeks / ☐ other: _____
- Dilute the required volume into an infusion bag containing 0.9% Sodium Chloride for a total volume of 200ml
- Infuse over 80 minutes (60ml/hr x 15 minutes, then increase to 180ml/hr for the remainder of the infusion)

☑ Flush with 0.9% sodium chloride at the completion of infusion

☐ Patient is required to stay for 30-minute observation period
☐ Patient is NOT required to stay for observation time
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

Provider Name (Print) **Provider Signature** **Date**

FAX NUMBERS

Fax this form, insurance card (both sides), demographics, recent H&P, labs, and supporting clinicals to:

☐ BAY AREA: 844-889-0275
☐ CHARLOTTE: 336-663-0143
☐ CINCINNATI: 844-946-0868
☐ CHICAGO: 312-253-7244
☐ COLUMBUS: 844-627-2675
☐ DAYTONA: 386-259-6096
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