Patisiran (Onpattro)

Provider Order Form rev. 10/6/2021

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**

Email ivxintake@ivxhealth.com or fax this form, insurance card (both sides), demographics, recent H&P, labs, and supporting clinicals to:

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