175MemorialHighway.Suite1-1
NewRochelle,NY
1080

914-460-489
fuse@fuseinfusion.com
914-460-4571

☐ _____ ok the switch to biosimilar if insurance formulary prefers

Date: _____

ONPATTRO (Patisiran) INFUSION orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

NPI _____ Tax ID _____

Insurance Carrier (primary) _____

Insurance Carrier (secondary) _____

DIAGNOSIS please attest to ICD-10 code

O E 85.1 Neuropathic heredofamilal amyloidosis

PRE-MEDICATION

O IV corticosteroid (dexamethasone 10mg, or equivalent

O oral acetaminophen (500mg)

O IV H1 Blocker (diphenhydramine 50mg or equivalent

O IV H2 Blocker (ranitidine 50mg or equivalent

for premeds not available or not tolerated intravenously, equivalents may be administered orally

ONPATTRO ORDERS

DOSAGE

0.3 mg/kg for patients < 100kg

30mg for patients ≥ 100kg

PATIENT WEIGHT

_____ lbs

_____kg

Frequency every 3 weeks

Notes

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____