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adaptIV infusion

# Onpattro (Patisiran)

*Provider Order Form rev. 4/10/2022*

## PATIENT INFORMATION

Referral Status *(check one)*: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____

NKDA ☐ Allergies: _____ Weight _____ *Please specify:* ☐ lbs ☐ kg Height: _____

Patient Status *(check one)*: ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

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

**REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

## PRESCRIPTION

### NURSING

☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation

### 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: _____

### LABORATORY ORDERS

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

### 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 180 ml/hr for the remainder of the infusion)

☐ Flush with 0.9% sodium chloride at infusion completion

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

## SPECIAL INSTRUCTIONS

## PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

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

**REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK**