VEROS HEALTH
Excellence in Complex Care

Patisiran (Onpattro®) Referral Form

Please complete the following and fax with clinical documentation to: 720.279.7461

Referral Process

1. PATIENT INFORMATION (*indicates a required field)	2. PHYSICIAN INFORMATION (*indicates a required field)
Name*: _____	Physician's name*: _____
Address*: _____	License #: _____ NPI #*: _____
City*: _____ State*: _____ Zip*: _____	DEA #: _____ Email*: _____
Home Phone: _____ Mobile Phone*: _____	Address*: _____
Email*: _____ Primary language*: _____	City*: _____ State*: _____ Zip*: _____
DOB*: _____ Social Security #*: _____	Office Contact: _____
Gender*: ☐ M ☐ F Height: _____ Weight*: _____	Phone*: _____ Fax*: _____ Specialty*: _____

Allergies*: _____ NKA*: ☐

Alternate contact name: _____ Alternate contact phone: _____

☐ Yes ☐ No* Consent to leave voice message at the patient and/or alternate contact phone

3. DIAGNOSIS

☐ **E85.1** Neuropathic heredofamilial amyloidosis

☐ Other diagnosis(es): _____

4. INSURANCE INFORMATION

Please submit copies of the front and back of primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION

Anticipated Start Date: _____

Prescription*: ONPATTRO® 10 mg/5 mL single-dose vial for intravenous use

Duration: 1 intravenous infusion every 3 weeks administered over 80 minutes. First two infusions must be administered in a controlled setting. If well tolerated, patient may receive subsequent infusions at home ***if approved*** by Soleo's Clinical Standards Committee.

Dose:

☐ For patients weighing less than 100 kg, the recommended dosage is (0.3 mg/kg) _____ (calculated dosage) once every 3 weeks

☐ For patients weighing 100 kg or more, the recommended dosage is 30 mg once every 3 weeks.

☐ **Pre-medicate with the following at least one hour prior to infusion:** Dexamethasone 10mg IV, acetaminophen 500mg PO, Diphenhydramine 50mg IV, and Famotidine 20mg IV (may substitute PO for IV if not tolerated or not available)

Additional orders: _____

Access: ☐ Peripheral Other: _____

FLUSH ORDERS

PIV/midline/PICC: Flush before, after each infusion, and as needed with 3-20 ml NS, followed by Heparin 2-5 ml if indicated

☐ Heparin 10 unit/ml ☐ Heparin 100 unit/ml

Port: Flush before, after each infusion, and as needed with 5-20 ml NS, followed by Heparin 100 unit/ml 5 ml.

ANAPHYLAXIS ORDERS

Adults: For mild reaction-administer diphenhydramine 50mg IVP/PO x 1.

For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs.

☐ Other: _____

Additional Instructions: _____

6.

PHYSICIAN'S SIGNATURE (required): _____ **Date:** _____

Prescription is valid for one year unless otherwise indicated. The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.