INTRAMED Plus
infusion services

ONPATTRO®

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: _____ Neuropathic heredofamilial amyloidosis ICD-10 Code: E85.1 _____

_____ Other: _____ ICD-10 Code: _____

Allergies: _____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes, labs, test supporting primary diagnosis
- Medication list
  - Patient has been advised regarding their need for Vitamin A supplementation

Patient
Weight: _____ lbs.
Height: _____ in.

ONPATTRO® (patisiran) J Code: J0222

4. Drug Order:

❑ Patient weight less than 100 kg (220 lbs):
Administer Onpattro 0.3 mg/kg IV (_____ mg) every three weeks

❑ Patient weight greater than 100 kg (220 lbs):
Administer Onpattro 30 mg every three weeks

_____ # Refills (Recommend 8)

Pre-Medication Orders: Acetaminophen 500 mg PO, Diphenhydramine 50 mg IV, Dexamethasone 10 mg IV, and Famotidine 20 mg IV
Administered 60 (sixty)minutes prior to infusion *Adjust to patient's needs

❑ Other: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name: _____ Contact Phone #: _____

FAX ALL INFORMATION	CENTRAL INTAKE PHONE
CENTRAL FAX **803.999.1754**	**803.999.1750**