ONPATTRO™ Infusion

OptiMed
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Please complete each section of the referral form below and fax to OptiMed along with a copy (front and back) of all the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents.

Prescriber Information

Prescriber: _____ **NPI:** _____

Phone: _____ **Fax:** _____ **Office Contact:** _____

Address: _____

Patient Information

Name: _____ **DOB:** _____ ☐**M** ☐**F**

Address: _____

Phone: _____ **2nd Phone:** _____ **SSN:** _____

Primary Language: _____ **Functional Limitations:** _____

Clinical Information

Diagnosis (include ICD-10 code): _____

Weight: _____ ☐lb ☐kg **Height:** _____ ☐in **IV access:** ☐PIV ☐PICC ☐Port ☐Other: _____

Patient's first dose? ☐Yes ☐No (If no, date of last dose: _____) **Prior infusion reactions:** _____

Allergies: _____ **Latex allergy?** ☐Yes ☐No

Prior treatments & reason for discontinuation: _____

_____

History of kidney disease: ☐Yes ☐No If yes, SCr: _____ GFR/CrCl: _____ **History of heart failure:** ☐Yes ☐No

Vitamin A: ☐Patient has been advised to supplement vitamin A daily
☐OptiMed to counsel patient regarding vitamin A supplementation

If female, could patient be pregnant?: ☐Yes ☐No

Prescription Information

Dosing Regimen	Rate	Quantity
☐ **Patient weight < 100kg:** Infuse ONPATTRO™ 0.3 mg/kg in 200mL NaCl 0.9% IV every three (3) weeks. Infuse over approximately 80 minutes. ☐ **Patient weight ≥ 100kg:** Infuse ONPATTRO™ 30 mg in 200mL NaCl 0.9% IV every three (3) weeks. Infuse over approximately 80 minutes.	Begin at an initial infusion rate of approximately 1mL/min for the first 15 minutes then increase to approximately 3mL/min for the remainder of the infusion, as tolerated.	_____ doses (infusions)

Nursing and Supplies: Must be infused through a dedicated line using a DEHP-free infusion set containing a 1.2-micron polyethersulfone (PES) in-line infusion filter. OptiMed to provide supply items and nursing care to prepare and administer product as per package instructions.

Premedication(s): Administer the following premedication's* at least 60 minutes prior to the start of the ONPATTRO™ infusion:
Dexamethasone 10mg in 50mL NaCl 0.9% IV over 15-20 minutes
Diphenhydramine 50mg IVP over 3-5 minutes
Ranitidine 50mg IV in 50mL NaCl 0.9% over 15-20 minutes
Acetaminophen 500mg PO
*As per the package insert, for premedication's that are unavailable or not tolerated intravenously, equivalents may be administered orally.

Additional Premedication(s): _____

PRN medication orders: _____

Post-Infusion: Flush IV set with 0.9% NaCl to ensure that all ONPATTRO™ has been administered.

Laboratory orders (subject to availability): List any outpatient laboratory work related to this therapy you would like OptiMed to draw in conjunction with the medication administration, including the frequency for each lab order. Lab orders are good for the life of the prescription order (one year) unless otherwise indicated.

_____

Prescriber Signature

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide infusion-related nursing services and supplies in conjunction with the therapy prescribed above.

Signature: _____ **Date:** _____

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