ONPATTRO
(patisiran)

FLOURISH™ HEALTH GROUP

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • History & Physical • Patient Demographics • Most Recent Labs • Medication List •Tried/Failed Therapies

• Patient has been advised to take Vitamin A supplementation: ☐ Y ☐ N

PRIMARY DIAGNOSIS

☐ E85.1 Neuropathic Heredofamilial Amyloid
☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the Flourish Health: _____

PRE-MEDICATIONS

☑ Per Flourish Health Protocol: Acetaminophen 650mg PO, Diphenhydramine 25mg IV, Methylprednisolone 100mg IV, and Famotidine (to begin 30 minutes prior to start of infusion).

☐ 20mg IV Provider Prescribed: _____

PRIMARY MEDICATION ORDER

☐ Onpattro 0.3 mg/kg IV every 3 weeks (if weight <100 kg)
☐ Onpattro 30 mg IV every 3 weeks (if weight >100kg)
☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Flourish Health Group's protocol (See flourishhealth.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per Flourish Health Group's protocol
(See flourishhealth.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

Provider Signature _____ Date _____