

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____
 ADDRESS: _____ CITY, STATE, ZIP: _____
 DATE OF BIRTH: _____ EMAIL: _____
 ALLERGIES: SEE LIST NKDA WEIGHT: LB OR KG

REQUIRED DOCUMENTATION

1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Most Recent Labs 5. Medication List
 6. Tried/Failed Therapies 7. Patient has been advised to take vitamin A supplementation: Yes No

PRIMARY DIAGNOSIS

E85.1 Neuropathic Heredofamilial Amyloidosis
 Other _____

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

Per infusion clinic protocol: Acetaminophen 650mg PO, Diphenhydramine 25mg IV, Methylprednisolone 100mg IV, and Famotidine 20mg IV 30
minutes prior to start of infusion
 Provider Prescribed: _____

PRIMARY MEDICATION ORDER

If Weight <100kg: Onpattro 0.3mg/kg (_____mg) IV every 3 weeks
 If Weight >100kg: Onpattro 30mg IV every 3 weeks
 Other: _____
 FIRST DOSE?: Yes No Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

Start PIV/ACCESS CVC Flush device per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
 Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

Administer acute infusion and anaphylaxis medications per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
 Other: (Please fax other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____
 OFFICE CONTACT: _____ FAX: _____
 ADDRESS: _____ EMAIL: _____
 CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

X _____
 PROVIDER SIGNATURE DATE