Onpattro Enrollment Form

Date: _____
Patient Name: _____
Date of Birth: _____

Cumberland Vital Care
Fax Referral To:
(931) 456-4857
Direct Phone: (931) 456-0680

PREVIOUS ADMINISTRATION

If YES, please provide the following information:	If NO, please indicate desired location for first dose:
Last Infusion Date: _____ Next Infusion Date: _____	☐ Physician's Office TwelveStone Infusion Center: ☐Canton ☐Chattanooga ☐Knoxville ☐Mount Juliet ☐Murfreesboro ☐ Other: _____ Desired Start Date: _____

DIAGNOSIS

Description	*ICD-10 Code*
☐ Polyneuropathy ☐ Neuropathic Heredofamilial Amyloidosis	☐ G63 ☐ E85.1

OTHER REQUIRED DOCUMENTATION *(Please attach documents as needed)*

☐ This signed order form
☐ History and Physical
☐ Patient Demographics and Insurance Information
☐ Clinical progress notes, lab work (including most recent renal function tests and any other tests supporting primary diagnosis)

CLINICAL INFORMATION *(Please attach all clinical information, lab results and other medical history documents)*

Patient Weight: : _____ Kg Height: _____ Inches/CM BSA : _____ Allergies: _____

Line Access: ☐ PIV ☐ PICC (SL DL TL) ☐ PORT (Huber size_____ Gauge_____ Length) ☐ Sub-Q

MEDICATION	DOSE	DIRECTIONS	REFILLS	BASELINE LABWORK REQ'D TO INITIATE (check for TwelveStone to Draw)
☐ Onpattro	10mg/5ml Vial	☐ < 100kg - Infuse 0.3mg/kg (_____ mg) IV over a minimum of 80 minutes every 3 weeks ☐ 100kg or > - Infuse 30 mg IV over a minimum of 80 minutes every 3 weeks		☐ CBC w/Differential ☐ Vitamin A Level

LAB ORDERS - to be drawn by TwelveStone

Order	Frequency
CBC w/Differential	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____
CBC w/o Differential	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____
CMP	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____
BMP	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____
CRP	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____
Sed Rate	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____
Calcium	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____
Tb QuantiFERON Gold	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____
Hepatitis Panel	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____
Other_____	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____

PRE-MEDICATIONS - *RECOMMENDED/If No Pre-Meds please check here _____

Oral

*Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg
Cetirizine: ☐ 10mg
*Diphenhydramine: ☐ 25mg ☐ 50mg
Famotidine: ☐ 20mg ☐ 40mg
Ibuprofen: ☐ 200mg
Loratadine: ☐ 10mg
Ondansetron: ☐ 4mg

IV

*Dexamethasone: ☐ 10mg
Diphenhydramine: ☐ 25mg ☐ 50mg
Famotidine: ☐ 20mg ☐ 40mg
Methylprednisolone: ☐ _____mg IV over _____ mins
Ondansetron: ☐ 4mg ☐ 8mg

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Physician's Phone #	Physician's NPI#	Physician's Fax #	Physician's Address
Dispense as Written	Date	Substitution Allowed	Date