MPP INFUSION CENTERS
A MULTISPECIALTY PHYSICIAN COMPANY

Fax Referrals To: (855) 891-2191
Email Referrals To: MPPReferral@mppinfusion.com
Have a Question? (855) 478-1528

ONPATTRO™ (PATISIRAN) ORDER FORM

(- Required Fields)*

_____ **New Referral** _____ **Order Renewal** _____ **Medication/Order Change**
_____ **Benefits Verification Only** _____ **Discontinuation Order**

PATIENT INFORMATION			
NAME*:		DOB*:	SEX: ☐M ☐F
ADDRESS:		PHONE:	
WEIGHT: ☐LBS ☐KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL *(FOR UPDATES)*:

ONPATTRO ORDER*:

ICD-10*: _____

*(SELECT **ONE** OF THE FOLLOWING)*

_____ **Less than 100 KG Dose**: 0.3 mg/kg IV every 3 weeks by intravenous infusion

_____ **Equal to or Greater than 100 KG Dose:** 30 mg IV every 3 weeks

Pre-medications: ___IV Dexamethasone 10mg ___Oral Acetaminophen 500mg ___IV Benadryl 50mg ___IV Ranitidine 50mg

Physician Signature* _____ **Date*(Order is Valid for One Year)** _____

Infusion will be administered per MPP policy and protocols

REQUIRED DIAGNOSIS:

_____ Neuropathic Heredofamilial Amyloidosis

_____ Other_____

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics

_____ Insurance Card/Information

_____ Clinical/Progress Notes supporting DX

_____ History and Physical

Last Infusion/Injection Date: _____

STANDING LAB ORDERS: _____ CMP _____ CBC _____ CRP _____ ESRP _____ HFR _____ UA

____ Labs to be drawn by Infusion Center Frequency _____

NOTES/ADDITIONAL COMMENTS:

Locations:

--------**Colorado**--------
___ Lakewood

---------**Florida**---------

----------**Texas**----------
___ Arlington
___ Dallas
___ Duncanville
___ Irving
___ Southlake
___ Lewisville
___ Plano
___ Tyler

REVISION DATE- 1/2019