MPP INFUSION CENTERS
www.mppinfusion.com

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

ONPATTRO™ (PATISIRAN) ORDER FORM

(- Required Fields)*

____ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

____ **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*:

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

ICD-10*: _____

____ **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_____

***STAT REASON:**
(STAT request will be assessed per MPP policy and protocol)

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

____ Labs to be drawn by Infusion Center Frequency _____

NOTES/ADDITIONAL COMMENTS:

Locations:

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

---------**Florida**---------
___ Jacksonville
___ Kissimmee
___ Port St. Lucie
___ Suncoast
___ Winter Park

-------- **Oklahoma**-------
___ Tulsa

----------**Texas**----------
___ Arlington
___ Cedar Hill
___ Dallas
___ Denton
___ Ft. Worth
___ Irving
___ Rockwall
___ Southlake
___ Flower Mound
___ Plano
___ Tyler

REVISION DATE- 10/2021