



Fax your completed order to 877-734-1157

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date of Last Infusion: \_\_\_\_/\_\_\_\_/\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Infusion Location: (state and site) \_\_\_\_\_

## Onpattro® (patisiran) Infusion Orders

Diagnosis (please provide ICD-10 code in space provided):

_____ Polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults
_____ Other:

Nursing Orders:

- Hold infusion and notify provider for:
  - Signs/symptoms of infection, planned/recent surgical procedures, recent live vaccines, new/worsening neurological or mood changes
- If an infusion-related reaction occurs, stop infusion and initiate Hypersensitivity Reaction Management Protocol as clinically indicated

Pre-medications Not optional, must be administered once 60 minutes prior to infusion):

Tylenol 500 mg PO	Solu-medrol 125 mg IVP	Ranitidine 50mg IV
Benadryl 50mg IV	<input type="checkbox"/> OTHER:	<input type="checkbox"/> OTHER:

Dosing:

<input type="checkbox"/> Weight less than 100kg: Onpattro 0.3mg x _____ kg=_____mg IV every 3 weeks
<input type="checkbox"/> Weight greater than or equal to 100kg: Onpattro 30mg IV every 3 weeks

- Medication must be filtered with a 0.45-micron polyethersulfone syringe filter
- Dilute in DEHP free NS bag to a final volume of 200ml
- Do not shake when mixing
- Infuse with 1.2-micron polyethersulfone in-line filter
- Monitor vitals at start of infusion and every 30mins
- Watch for infusion related reaction
- Infuse per chart below (do not infuse over less than 80mins)

Volume (ml)	Infusion Rate (ml/hr)
15ml	60ml/hr
50ml	100ml/hr
135ml	180ml/hr

Provider Name (print) \_\_\_\_\_ Date: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Time: \_\_\_\_\_