



Onpattro Order Form

Select patient referral location: Blue Ash Worthington Crestview Hills Springfield West Cincinnati
Fax completed form to 888-977-0914. For new referrals, please include recent labs and last two office visit notes.

Toll Free Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: <input type="checkbox"/> Lbs <input type="checkbox"/> Kg
Patient Status: <input type="checkbox"/> New to therapy <input type="checkbox"/> Continuing therapy <input type="checkbox"/> Next due date (if applicable):	

2. PHYSICIAN INFORMATION

Physician's name:	NPI#:	
License #: <input type="text"/>	TIN#: <input type="text"/>	
DEA#: <input type="text"/>		
Address: <input type="text"/>		
City: <input type="text"/>	State: <input type="text"/>	Zip: <input type="text"/>
Office contact: <input type="text"/>	Email: <input type="text"/>	
Office phone: <input type="text"/>	Office fax: <input type="text"/>	

3. DIAGNOSIS INFORMATION (and year of diagnosis)

Polyneuropathy Hereditary Transthyretin-Mediated Amyloidosis ICD 10 () Other (specify):

4. INSURANCE INFORMATION

Please submit copies of the front and back or primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION (requires new order every 12 months)

ONPATTRO

- Under 100 kg: 0.3 mg/kg every 3 weeks IV
- Over 100 kg: 30 mg every 3 weeks IV

- Vital signs per HI Protocol
- Anaphylaxis & Hydration Management per HI Protocol

PRE-MEDICATIONS N/A

- Acetaminophen 500mg 650mg 1000mg PO
- Fexofenadine (Allegra) 180mg PO (or other non-sedating anti-histamine)
- Diphenhydramine (Benadryl) 25mg 50mg PO IV (requires driver)
- Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV
- Prednisone _____ mg PO
- Other: _____

POST-MEDICATIONS N/A

- Acetaminophen 500mg 650mg 1000mg PO
- Prednisone _____ mg PO
- Other: _____

6. LABS

- | | | |
|--|--|---|
| <input type="checkbox"/> CBC w/Diff | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> CRP | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> CMP | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> ESR | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> Hepatic Panel | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> Renal Panel | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
- Quantiferon TB Gold, annually, last completed (date): _____
- Other (specify): _____

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE