AYSA
THERAPEUTICS INFUSION

ONPATTRO (PATISIRAN) ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

Diagnosis: ☐ Polyneuropathy of hereditary transthyretin mediated amyloidosis ICD-10 Code: _____

Patient Weight: _____ lbs. Allergies: _____

☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis attached

☐ Patient has been advised to take Vitamin A supplementation

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

ONPATTRO ORDERS

Less than 100kg

☐ 0.3mg/kg IV every 3 weeks

Greater than 100kg

☐ 30mg IV every 3 weeks

Protocol Pre-medications to be given 1 hour prior to infusion:

☐ Solu-medrol 125mg IV, Tylenol 500mg PO, Benadryl 50mg IV, Pepcid 20mg IV

☐ Other: _____

****Once we receive all necessary documentation, we wil schedule the patient's treatment.**

ADDITIONAL ORDERS/COMMENTS

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc.*, and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Physician Name: _____ Date: _____
Phone: _____ Fax: _____ Contact Person: _____