Onpattro™ (patisiran) Referral Form

BIOHEALTH
INFUSION CENTER

www.biohealthic.com | info@biohealthic.com

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

NKDA Allergies: Weight (lbs/kg): Height:

ICD-10 code (required): ICD-10 description: Last Treatment Date: Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Infusion to be administered per BioHealth protocols.

LABORATORY ORDERS

CBC At each dose Every ______________________

CMP At each dose Every ______________________

CRP At each dose Every ______________________

OTHER

PREMEDICATIONS

acetaminophen (Tylenol) 500 mg 650 mg 10000 mg PO

cetirizine (Zyrtec) 10mg PO

loratadine (Claritin) 10mg PO

diphenhydramine (Benadryl) 25 mg 50 mg PO IV

methylprednisolone (Solu-Medrol) 40mg 125mg IV

hydrocortisone (Solu-Cortef) 100mg IV

Other: ____

Dose: ________________ Route: _____________________

ONPATTRO THERAPY ADMINISTRATION

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

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

REQUIRED DOCUMENTATION

Patient Demographics

Insurance Card/Information

Progress Notes Supporting DX

Current Medication List and H&P

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Provider Name (Print) **Provider Signature** **Date**

Have a Question? (786)460-6044

Fax Referral Form To: (786)219-3917

8684 SUNSET DRIVE MIAMI FL 33143