

PATIENT DEMOGRAPHICS

Insurance Information: Please attach copy of insurance card front and back (required)

Patient Name: _____ DOB: _____ Phone: _____
 Address: _____ City/ST/Zip: _____
 Allergies: _____ NKDA Weight: _____ lbs kg Height: _____ in cm

DIAGNOSIS*

ICD-10 CODE (required)

Please complete 2nd and 3rd digits to complete ICD-10 for billing

E85.1 Neuropathic Heredofamilial Amyloidosis Other: _____, ICD-10 _____

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION	
Onpattro (patisiran)	<input type="checkbox"/> 0.3mg/kg <input type="checkbox"/> 30mg	<input type="checkbox"/> Weight of less than 100kg: 0.3mg/kg IV once every 3 weeks <input type="checkbox"/> Weight of 100kg or greater: 30mg IV once every 3 weeks	<input type="checkbox"/> Prescriber has advised patient to supplement with recommended daily allowance of Vitamin A <input type="checkbox"/> Pre-Medications will be given as indicated below unless otherwise specified
Oral:		IV:	Refills:
Acetaminophen: <input type="checkbox"/> 325mg <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg		Dexamethasone: <input type="checkbox"/> 4mg <input type="checkbox"/> 8mg <input type="checkbox"/> 10mg	Refills for one year from date of signature unless indicated below _____ Refills
Loratadine: <input type="checkbox"/> 10mg		Diphenhydramine: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg	
Cetirizine: <input type="checkbox"/> 10mg		Famotidine: <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg	
Diphenhydramine: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg		Methylprednisolone: <input type="checkbox"/> 125mg	
Ibuprofen: <input type="checkbox"/> 200mg <input type="checkbox"/> 400mg <input type="checkbox"/> 600mg		Hydrocortisone: <input type="checkbox"/> 100mg	
Ondansetron: <input type="checkbox"/> 4mg <input type="checkbox"/> 8mg		Ondansetron: <input type="checkbox"/> 4mg <input type="checkbox"/> 8mg	
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Other: _____	

Is patient currently receiving therapy above from another facility? NO YES
 If yes, Facility Name: _____ Date of last treatment: _____ Date of next treatment: _____

OTHER ORDERS

LAB ORDERS: Labs to be drawn by: Infusion Center Referring Physician
 No labs ordered at this time
 CBC q _____ CMP q _____ CRP q _____ ESR q _____ LFTs q _____ Other: _____

PRE-MEDICATION ORDERS:
 No premeds ordered at this time Diphenhydramine 25mg PO Other: _____
 Acetaminophen 650mg PO Methylprednisolone 40mg IVP -OR- Hydrocortisone 100mg IV

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____
 Physician Name: _____ Provider NPI: _____ Specialty: _____
 Address: _____ City/ST/Zip: _____
 Contact Person: _____ Phone #: _____ Fax #: _____
 Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis

TEST RESULTS (required)

- TB screening for Actemra, Cimzia, Cosentyx, infliximab biosimilars, Orencia, and Simponi Aria (submit results from within 12 months to start therapy and annually to continue therapy)
 - Annual TB screening to be done by: Infusion Center Referring Physician
- Hepatitis B Screening for Cimzia, infliximab biosimilars, Orencia, Simponi Aria, tocilizumab biosimilars and Rituxan (submit results to start therapy)

DIAGNOSTIC TEST RESULTS (please attach copy for all items checked)

For SLE: Autoantibody test (ANA, anti-dsDNA)

PRIOR FAILED THERAPIES (including DMARDs, immunosuppressants, and biologics)

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
 Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
 Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
 Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
 Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____