Onpattro Enrollment Form

Date: ______________________
Patient Name: ______________________
Date of Birth: ______________________

TwelveStone Health Partners
Fax Referral To:
(800) 223-4063
Direct Phone: (615) 278-3350
Toll Free: (844) 893-0012

PREVIOUS ADMINISTRATION

If YES, please provide the following information:	If NO, please indicate desired location for first dose:
Last Infusion Date: ______________________ Next Infusion Date: ______________________	☐ Physician's Office TwelveStone Infusion Center: ☐Canton ☐Chattanooga ☐Knoxville ☐Mount Juliet ☐Murfreesboro ☐ Other: ______________________ Desired Start Date: ______________________

DIAGNOSIS

Description	*ICD-10 Code*
☐ Polyneuropathy ☐ Neuropathic Heredofamilial Amyloidosis	☐ G63 ☐ E85.1

OTHER REQUIRED DOCUMENTATION *(Please attach documents as needed)*

☐ This signed order form	☐ History and Physical
☐ Patient Demographics and Insurance Information	☐ Clinical progress notes, lab work (including most recent renal function tests and any other tests supporting primary diagnosis)

CLINICAL INFORMATION *(Please attach all clinical information, lab results and other medical history documents)*

Patient Weight: :________ Kg Height: __________Inches/CM BSA :______________ Allergies: ______________________

Line Access: ☐ PIV ☐ PICC (SL DL TL) ☐ PORT (Huber size________Gauge_____Length) ☐ Sub-Q

MEDICATION	DOSE	DIRECTIONS	REFILLS	BASELINE LABWORK REQ'D TO INITIATE (check for TwelveStone to Draw)
☐ Onpattro	10mg/5ml Vial	☐ < 100kg - Infuse 0.3mg/kg (_____ mg) IV over a minimum of 80 minutes every 3 weeks ☐ 100kg or > - Infuse 30 mg IV over a minimum of 80 minutes every 3 weeks		☐ CBC w/Differential ☐ Vitamin A Level

LAB ORDERS - to be drawn by TwelveStone

Order	Frequency
CBC w/Differential	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
CBC w/o Differential	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
CMP	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
BMP	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
CRP	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
Sed Rate	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
Calcium	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
Tb QuantiFERON Gold	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
Hepatitis Panel	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
Other____________________________________	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________

PRE-MEDICATIONS - *RECOMMENDED/If No Pre-Meds please check here _____

Oral	IV
*Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg	*Dexamethasone: ☐ 10mg
Cetirizine: ☐ 10mg	Diphenhydramine: ☐ 25mg ☐ 50mg
*Diphenhydramine: ☐ 25mg ☐ 50mg	Famotidine: ☐ 20mg ☐ 40mg
Famotidine: ☐ 20mg ☐ 40mg	Methylprednisolone: ☐ _____mg IV over ______ mins
Ibuprofen: ☐ 200mg	Ondansetron: ☐ 4mg ☐ 8mg
Loratadine: ☐ 10mg	
Ondansetron: ☐ 4mg	

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

______________________	______________________	______________________	______________________
Physician's Phone #	Physician's NPI#	Physician's Fax #	Physician's Address
______________________	______________________	______________________	______________________
Dispense as Written	Date	Substitution Allowed	Date

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