

# TwelveStone Health Partners

Fax Referral To: (615) 278-3355

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Email: referral@12stonehealth.com



## ONPATTRO ORDER FORM

Patient Name: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Allergies: \_\_\_\_\_  
Weight: \_\_\_\_\_ lbs OR \_\_\_\_\_ kg

### Therapy Status

New Start  
 Continuing Therapy: Last Dose: \_\_\_\_\_

## PROVIDER INFORMATION

Ordering Provider: \_\_\_\_\_ Provider Fax: \_\_\_\_\_  
Provider NPI: \_\_\_\_\_ Provider Address: \_\_\_\_\_  
Provider Phone: \_\_\_\_\_

## MEDICATION ORDER

<b>Onpattro</b>	<input type="checkbox"/> Weight of less than 100kg: Onpattro 0.3mg/kg IV once every three weeks	Refills for one year from date of signature unless indicated below.  _____ Refills
	<input type="checkbox"/> Weight of 100kg or greater: Onpattro 30mg IV once every three weeks	
	<input checked="" type="checkbox"/> Prescriber should advise patient to supplement with recommended daily allowance of Vitamin A	
	<input checked="" type="checkbox"/> Pre-Medications will be given as indicated below unless otherwise specified	

## PRE-MEDICATIONS

<b>Oral</b> <input checked="" type="checkbox"/> Acetaminophen: _____ 325mg <input checked="" type="checkbox"/> 500mg _____ 650mg <input type="checkbox"/> Loratadine: 10mg <input type="checkbox"/> Cetirizine: 10mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____	<b>IV</b> <input checked="" type="checkbox"/> Dexamethasone: _____ 4mg _____ 8mg <input checked="" type="checkbox"/> 10mg <input checked="" type="checkbox"/> Diphenhydramine: _____ 25mg <input checked="" type="checkbox"/> 50mg <input checked="" type="checkbox"/> Famotidine: <input checked="" type="checkbox"/> 20mg _____ 40mg <input type="checkbox"/> Methylprednisolone: 125mg <input type="checkbox"/> Hydrocortisone: 100mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____
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## LAB ORDERS (please indicate any labs to be drawn and frequency)

## OTHER REQUIRED DOCUMENTATION

\*\*Surveillance lab ordering and monitoring is the responsibility of the prescriber\*\*

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

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

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date