

Amyloidosis Therapy Order Form Amvuttra (vutrisiran), Onpattro (patisiran)

Patient Name: _____ DOB: _____ Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____

1. For new patients, please submit with form:

- Copy of insurance card
- Patient demographics
- History & physical
- Pertinent labs and test results

2. Patient Information

Male Female Height: _____ in/cm Weight: _____ lbs/kg NKDA Allergies: _____
 Is this the first dose? Yes No, date of last infusion: _____ Next due: _____
 Line type (if applicable): PIV PICC Port Other

3. Diagnosis and Clinical Information

- E85.1 Neuropathic hereditary amyloidosis (polyneuropathy of hereditary transthyretin-mediated amyloidosis)
- Other ICD-10 code: _____ Description: _____

4. Prescription Information

Medication	<input type="checkbox"/> Amvuttra (vutrisiran): 25 mg (0.5 mL) subcutaneously once every 3 months <input type="checkbox"/> Onpattro (patisiran): 0.3 mg/kg up to max of 30 mg (Weight = _____ kg) IV infusion once every 3 weeks <input type="checkbox"/> Other: _____
Directions	<input type="checkbox"/> Amvuttra: Administer subcutaneously as directed per manufacturer guidelines <input type="checkbox"/> Onpattro: Filter and then dilute the required volume of Onpattro into an infusion bag containing NS for a total volume of 200 mL, per manufacturer guidelines. Administer using 1.2 micron in-line filter over approximately 80 minutes, titrated per manufacturer guidelines and line flushed upon completion. <input type="checkbox"/> Other: _____
Quantity / Refills	<input type="checkbox"/> Dispense 1 dose / Refill x 12 months <input type="checkbox"/> Other: _____ Dispense all medical supplies necessary for IV infusion or SUBQ injection

5. Additional Orders

- **Amvuttra Pre-medications:** No pre-medications unless ordered: _____
- **Onpattro Pre-medications:** Give the following on the day of infusion at least 60 minutes prior to start of Onpattro infusion
 - Methylprednisolone 80mg (OR _____ mg) slow IV push (or an equivalent corticosteroid, substitution if needed by pharmacy)
 - Diphenhydramine 50 mg (OR _____ mg) slow IV push
 - Famotidine 20 mg (OR _____ mg) slow IV push (or an equivalent H2 blocker, substitution if needed by pharmacy)
 - Acetaminophen 500-650mg (OR _____ mg) by mouth
 - Other: _____
- RN to start peripheral IV or use existing CVC for Onpattro infusions. RN to administer catheter flushing per PromptCare Policy and Procedure
- RN to instruct patient to hydrate pre/post infusion and educate on taking OTC diphenhydramine and/or acetaminophen per manufacturer dosing recommendations as needed to prevent/treat post-infusion headache.
- RN to monitor patient for minimum of **60 min following Onpattro** infusion or **30 minutes following Amvuttra** injection, and educate on possible side effects, allergic reactions, and when to contact physician
- Other: _____

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6. **Adverse Reaction Orders**

For **Amvuttra**: **No** adverse reaction / anaphylaxis kit to be dispensed unless otherwise ordered by provider:

For **Onpattro**: Standard anaphylaxis kit to be dispensed and dosed per protocol:
Epinephrine IM/SQ (1 mg/mL vial), diphenhydramine IV/IM (50 mg/mL vial), and NS IV.
Additional orders: _____

7. **Prescriber Information**

Prescriber Name: _____ Office Contact: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
License No.: _____ DEA NO.: _____ NPI: _____

Physician Signature (Substitution Permitted)	Date	Physician Signature (Dispense as Written)	Date
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