PARAGON HEALTHCARE

A Carelon Company

ONPATTRO (PATISIRAN) INFUSION ORDERS

P: 877-365-5566 | **F:** 855-889-2946

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:		Gender: ☐ Female ☐ Male	
Address:		City:	State:	ZIP:	
Phone:	Email:	Height:	☐ inches ☐ cm	Weight:	☐ lbs. ☐ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: ☐ New to Therapy ☐ Continuing Therapy		Next Treatment Date:			

PHYSICIAN INFORMATION

Prescriber Name:		Phone:	Fax:
Office Contact:			Email:
Address:		City: State:	ZIP:
NPI #:	DEA#:		Tax ID:

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing	Refills
Onpattro (patisiran)	☐ 0.3mg/kg IV every 3 weeks (<100kg) ☐ 30mg IV every 3 weeks (≥100kg)	☐ x 1 year ☐ _____

Protocol Pre-medications to be given 1 hour prior to infusion (unless contraindicated):

- Solu-medrol 125mg IV, acetaminophen 500mg PO, diphenhydramine 50mg IV, famotidine 20mg IV

☐ Other pre-medications: _____

Other orders: _____

Lab orders: _____ Lab Frequency: _____

Required labs to be drawn by: ☐ Paragon ☐ Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PRESCRIBER SIGNATURE

By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Prescriber Signature: X **Date:**

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COMPREHENSIVE SUPPORT FOR ONPATTRO (PATISIRAN) THERAPY

PATIENT INFORMATION

Name: DOB:

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

☐ Include signed and completed order (MD/prescriber to complete page 1)

☐ Include patient demographic information and insurance information

☐ Include patient's current medication list

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

- Please indicate any symptoms the patient currently has:
  ☐ Tingling/pain in hands/feet ☐ Loss of feeling in hands/feet
  ☐ Abnormal sweating ☐ Nausea/vomiting ☐ Anorexia ☐ Other: _____
- Does the patient have a baseline polyneuropathy disability (PND) score ≤ IIIb?
  ☐ Yes ☐ No
- Does the patient have a baseline FAP Stage 1 or 2? ☐ Yes ☐ No

☐ Documentation that the patient has a gene TTR mutation

☐ Confirmation the member is not a liver transplant recipient

☐ Patient has been advised to take Vitamin A supplementation

☐ Include labs and/or test results to support diagnosis (attach)

Diagnosis of hATTR amyloidosis with polyneuropathy confirmed by the following:

☐ Electromyography (EMG) or nerve conduction velocity (NCV) results or;

☐ Confirmed diagnosis of hATTR amyloidosis/FAP as documented by amyloid deposition on tissue biopsy

☐ Other medical necessity: _____