Hy-Vee health INFUSION CARE

ONPATTRO (PATISIRAN)
Infusion Orders

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

Patient Name: _____ **DOB:** _____ **Phone:** _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:** _____

Medical Information

Diagnosis: ☐ Polyneuropathy of hereditary transthyretin mediated amyloidosis

ICD-10 Code: E85.1

Patient Weight: _____ lbs. (required) **Allergies:** _____

Therapy Order

Onpattro

☐ <100kg – 0.3 mg/kg IV every 3 weeks x1 year

☐ >100kg – 30 mg IV every 3 weeks x1 year

Protocol premedications to be given 1 hour prior to infusion (unless contraindicated):

- Solu-Medrol 125 mg IV, Tylenol 500 mg PO, Benadryl 50 mg IV, Pepcid 20 mg IV

☐ Other premedications: _____

Lab Orders: _____ **Lab Frequency:** _____

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Provider

Other orders: _____

Provider Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* 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.

Provider Name: _____ **Signature:** _____ **Date:** _____

Provider NPI: _____ **Phone:** _____ **Fax:** _____ **Contact Person:** _____

☐ Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): _____

Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX

☐ Phoenix, AZ ☐ Other _____

HY-VEEHEALTHINFUSION.COM

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COMPREHENSIVE SUPPORT FOR ONPATTRO (PATISIRAN) THERAPY

Patient Information

Patient 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 patient 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: _____

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

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