promptcare

Intake Specialist 866-776-6782
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Amyloidosis Therapy Order Form
Amvuttra (vutrisiran), Onpattro (patrisiran)

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 heredofamilial amyloidosis (polyneuropathy of hereditary transthyretin-mediated amyloidosis)
   ☐Other ICD-10 code: __________ Description: ______________________________
4. **Prescription Information**

Medication	☐**Amvuttra** (vutrisiran): 25 mg (0.5 mL) subcutaneously once every 3 months ☐**Onpattro** (patrisiran): 0.3 mg/kg up to max of 30 mg (Weight = ______ kg) IV infusion once every 3 weeks ☐**Other**: ____________________
Directions	☐ **Amvuttra**: Administer subcutaneously as directed per manufacturer guidelines ☐ **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. ☐ **Other**: ____________________
Quantity / Refills	☐ Dispense 1 dose / Refill x 12 months ☐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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