***Conveniently Located in East Syracuse, Onondaga Hill & Auburn***
Main Office Phone 315-472-7504
Nurse Navigator Phone 315-506-2469
Main Fax 315-634-5168

## Onpattro (Patisiran) Non-Oncology Treatment Order Set

**1. Patient Name:** _____

**2. DOB:** _____ **Height (inches):** _____ **Weight (lbs):** _____

**3. Diagnosis:**

[ ] Primary ICD-10 Code: _____ Diagnosis description: _____
[ ] Other ICD-10 Code: _____ Diagnosis description: _____

**4. Pre-medications:**

[ ] Acetaminophen:
[ ] **1000mg PO** [ ] **500mg PO**
[ ] Diphenhydramine:
[ ] **25mg PO** [ ] **50mg PO** [ ] **25mg IV** [ ] **50mg IV**
[ ] Hydrocortisone: 100mg IVP
[ ] Other Pre-medication: _____
[ ] No Pre-medications indicated

**5. Drug Order:**

**Onpattro (Patisiran)** *Ok to substitute with generic/biosimilar*

[ ] Less than 100kg: 0.3mg/kg once every 3 weeks IV
[ ] Greater or equal to 100kg: 30mg once every 3 weeks IV

[ ] Special Instructions: _____
[ ] New to Therapy
[ ] Continuing therapy: Last Dose Received _____ Next Dose Due _____

*HOA of CNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation & management of drug hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. Any changes in condition or delayed adverse events that occur after leaving the infusion center are to be reported to the prescribing physician for evaluation & management. The prescribing physician is responsible for educating the patient of potential risks & complications associated with drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Infusion Referral*

**6. Infusion Lab Requirements:**

[ ] CBC & CMP annually
[ ] Other: _____
[ ] No lab monitoring indicated

*HOA of CNY WILL NOT DRAW LAB WORK REQUIRED FOR INFUSION ADMINISTRATION.*
*The prescribing physician is responsible for ordering, obtaining, reviewing all laboratory results & providing copy to HOACNY prior to infusion as ordered above.*

7. **Required Baseline Lab/Testing completed**:

[ ] CBC/CMP, date: _____ [ ] Other: _____ [ ] None

8. **Patient Assistance & REMS Program Enrollment**

[ ] Yes, patient has been enrolled in _____ program. (Provide Copy Enrollment Forms)
[ ] No, patient has not been enrolled in any programs.

7. **Physician's Name**: _____ **Phone:** _____
**Physician's Signature**: _____**Date:** _____

***(This drug administration order form is valid for 12 months)***