

Patient Information

Patient Name:	DOB:	Phone:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>
Patient Address:	Email:	Insurance:	

Additional Information Needed

- | | | |
|---|--|---|
| <input type="checkbox"/> Fax front/back of insurance card | <input type="checkbox"/> Fax clinical/progress notes | <input type="checkbox"/> Fax labs |
| <input type="checkbox"/> Fax patient demographics | <input type="checkbox"/> Fax current medication list | <input type="checkbox"/> Fax TB and Hep B results |

Diagnosis and Clinical Information
Diagnosis (ICD-10):

- E85.1 Neuropathic Heredofamilial Amyloidosis
 Other: Code: _____ Description: _____

Clinical Information:

- New Therapy Induction Therapy Change Therapy Continuation
 Patient Weight: _____ lbs / _____ kg Patient Height: _____ in / _____ cm
 Allergies: _____
 Therapies Tried and Failed: _____
 TB Test: Date: _____ Results: _____ Hep B Test: Date: _____ Results: _____

Lab Orders

- CBC CMP Vitamin A
 Other _____

Lab Orders to be done by

- Oklahoma Infusion Services
 Referring Provider

Prescription Information

- | | | |
|-----------------------------------|--|---|
| <input type="checkbox"/> Onpattro | <input type="checkbox"/> Dose: 0.3mg/kg (Patient Weight <100kg) | <input type="checkbox"/> Frequency: every 3 weeks |
| | <input type="checkbox"/> Dose: 30mg (Patient Weight 100kg or more) | <input type="checkbox"/> Frequency: every 3 weeks |

Pre-Medication Orders

- Corticosteroid (Solu-Cortef 250mg or Solu-Medrol 50mg) SIVP Famotidine 20mg PO
 Acetaminophen 500-1000mg PO Other: _____
 Diphenhydramine 50mg SIVP

Note: Pre-medications should be given at least 60 minutes prior to the start of infusion.

Standing Orders for Adverse Reactions

- | | |
|--|---|
| <input checked="" type="checkbox"/> Stop infusion and initiate NS bolus | <input checked="" type="checkbox"/> Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis |
| <input checked="" type="checkbox"/> Notify supervising physician and ordering provider | <input checked="" type="checkbox"/> Oxygen 2-5L nasal cannula |
| <input checked="" type="checkbox"/> Solu-Cortef 100mg SIVP signs of adverse reaction | <input checked="" type="checkbox"/> Albuterol 2.5mg inhaled PRN for chest tightness |
| <input checked="" type="checkbox"/> Benadryl 25mg SIVP for hives or bronchial inflammation | <input type="checkbox"/> Other: _____ |

Prescriber Information

Prescriber Name:		Office Contact Name:	
NPI #:	DEA #:	Contact Phone:	Contact Fax:

Prescriber's Signature: _____

Date: _____

By signing this form, you are authorizing Oklahoma Infusion Services and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.