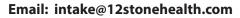
TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





ONPATTRO ORDER FORM					
Date: ICD-10 Code:		CD-10 Code:			Therapy Status
Patient Name:		_ Allergies:		☐ New Start	
Date of Birth:		Veight:Ibs OR	kg	☐ Continuing Therapy: Last Dose:	
PROVIDER INFORMATION					
Orderin	g Provider:		Provider Fax:		
Provider NPI:			Provider Address:		
Provider Phone:					
MEDICATION ORDER					
Onpattro	□ Weight of less than 100kg: Onpattro 0.3mg/kg IV once a Weight of 100kg or greater: Onpattro 30mg IV once a Prescriber should advise patient to supplement with of Vitamin A ✓ Pre-Medications will be given as indicated below unless than 100kg: Onpattro 0.3mg/kg IV once a patient to supplement with of Vitamin A			eks I daily allowance	Refills for one year from date of signature unless indicated belowRefills
PRE-MEDICATIONS					
Oral ✓ Acetaminophen:325mg			IV ✓ Dexamethasone:4mg8mgX10mg ✓ Diphenhydramine:25mgX50mg ✓ Famotidine:X20mg40mg □ Methylprednisolone: 125mg □ Hydrocortisone: 100mg □ Ondansetron:4mg8mg □ Other:		
LAB ORDERS (please indicate any labs to be drawn and frequency)			OTHER REQUIRED DOCUMENTATION		
	is form, I am authorizing TwelveStone Health I	nat the above therapy is med Partners and affiliates to serve as n	(Please fax this signed order form, along with the following documents to 800-223-4063) • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work ically necessary. Prescriber's Signature (SIGN BELOW) by designated agent in submitting prior authorizations and other clinically required information and form shall serve as my signature for prior authorizations, as requested.		
Dispense a		Date	Substitution All Prescriber Sig		
I I COCIDE	oignature	Date	I rescriber Sign	nature	Dal€