Amvuttra® (Vutrisiran)

Provider Order Form Rev. 07/2023

Please fax completed referral form & all required documents to (833) 786-0025

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Neuropathic heredofamilial amyloidosis, E85.1

☐ Other: _____, ICD10 _____

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Amvuttra® (vutrisiran)	25 mg	Inject SC once every 3 months x 1 year.

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: _____

Date of last treatment:_____ Date of next treatment:_____

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO

☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP

☐ Other: _____

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____

☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI:_____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply:

☐ Diagnosis is confirmed by detection of a mutation in the transthyretin (TTR) gene? ***Please attach copy of test results, if available.***

☐ The patient exhibits clinical signs and symptoms of the disease (e.g., peripheral sensorimotor polyneuropathy, autonomic neuropathy, motor disability, etc.).

- Polyneuropathy Disability Score: _____

☐ The patient has not received a liver transplant.

LAB AND TEST RESULTS (required)

☐ TTR genetic test result

☐ EMG/NCV report