

Vutisiran (Amvuttra)

Provider Order Form rev. 01/02/2024

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____ Patient Phone: _____

Patient Address: _____ Patient Email: _____

Allergies: _____ NKDA Weight (lbs/kg): _____ Height (in/cm): _____

Sex: M / F Date of Last Infusion: _____ Next Due Date: _____ Preferred Location: _____

DIAGNOSIS (Please provide ICD-10 code in space provided)

Polyneuropathy of hereditary transthyretin-mediated amyloidosis: _____

Other: _____ Description: _____

THERAPY ADMINISTRATION

Administer Amvuttra 25mg subcutaneously every 3 months

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

Other: _____

NURSING

- Hold infusion and notify provider if the patient is having ocular symptoms.
- Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation
- Continue Vitamin A supplements if prescribed by doctor

PROVIDER INFORMATION

Preferred Contact Name: _____ Preferred Contact Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, Supporting documentation of the diagnosis of hereditary transthyretin-mediated (hATTR) amyloidosis.

Provider Name (print)

Provider Signature

Date

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.