AMVUTTRA (VUTRISIRAN) ORDER FORM

PATIENT INFORMATION

Patient Name: ______________________ DOB: __________

Mobile Number: ______________________ Patient Weight: __________ kg

Allergies: ______________________

❑ New Start Therapy | ❑ Continuation of Therapy & Date of last dose (if applicable): __________

DIAGNOSIS (Provider must specify)

❑ Polyneuropathy of hereditary transthyretin-mediated amyloidosis (hATTR-PN), ICD 10: E85.1.

❑ Wild-type transthyretin-mediated amyloidosis (ATTR-CM), ICD 10: E85.82.

❑ Other: ______________________ ICD 10: __________

PROVIDER INFORMATION

Provider Name (print name): ______________________ Provider NPI: __________

Signature: ______________________ Date: __________

Contact Name: ______________________ Phone: __________ Fax: __________

Email Address: ______________________

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO ❑ Famotidine 20 mg IV ❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Benadryl 25mg PO ❑ Cetirizine (Zyrtec) 10 mg PO

❑ Other: ______________________ Dose: __________ Route: __________

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Amvuttra	25mg	Subcutaneous Inj	every 3 months x 1 year

OTHER NOTES

Order valid for 1 year from date of signature unless otherwise specified here: __________