Amvuttra Order Form
(vutrisiran)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

Primary ICD 10 Code

☐ E85.1 Neuropathic Heredofamilial Amyloidosis

Prescribing information

- Reduced serum vitamin A levels and recommended supplementation: Supplement with the recommended daily allowance of vitamin A. Refer to an ophthalmologist if ocular symptoms suggestive of vitamin A deficiency occur
- If a dose is missed, administer AMVUTTRA as soon as possible. Resume dosing every 3 months from the most recently administered dose

***REQUIRED*: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**
***LAB RESULTS*: Serum TTR, PND Scores, FAP Stage, or modified Neuropathy Impairment Scores and/or tests to support diagnosis.**

PRESCRIPTION

AMVUTTRA (vutrisiran)

Administer 25 mg by subcutaneous injection once every 3 months for one year

Post Treatment Observations: The patient is observed for 30 minutes following the first administration.

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

Comments:

_____

_____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____