# 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

**Is the patient on any other disease modifying therapy?** ☐ **Yes** ☐ **No**
**If yes, please note therapy and last dose:** _____

**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: _____