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: _____

Diagnosis

ICD 10 Code Required

☐ E85.1 Neuropathic heredofamilial amyloidosis
☐ E85.82 Cardiomyopathy of wtATTR amyloidosis
☐ E85.4 Cardiomyopathy of hATTR amyloidosis

☐ Other ICD Code: _____
Description: _____

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 occurs.
- If a dose is missed, administer AMVUTTRA as soon as possible. Resume dosing every 3 months from the most recently administered dose.

Medication Order

AMVUTTRA (vutrisiran)

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

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

Lab Orders+
Requested Add'l Lab Orders:
_____
_____
_____

Comments:
_____
_____

Required Clinical Documentation

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.**

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

Referring Provider Information

Signature: _____ Date: _____

Prescriber Name: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

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