

# AMVUTTRA (VUTRISIRAN) ORDER FORM

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Mobile Number: \_\_\_\_\_ Patient Weight: \_\_\_\_\_ kg  
 Allergies: \_\_\_\_\_

## DIAGNOSIS (Provider must specify)

- Polyneuropathy of hereditary transthyretin-mediated amyloidosis, ICD 10: E85.1 \_\_\_\_\_
- Wild-type transthyretin-mediated amyloidosis (ATTR), ICD 10: E85.82
- Other: \_\_\_\_\_

## 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	q 3 months

- New Start Therapy
- Continuation of Therapy
- Date of last dose (if applicable): \_\_\_\_\_

## LABS / SPECIAL INSTRUCTIONS

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

**FAX NUMBERS:**

- CT: 203.433.0621
- FL: 904.877.9270

- MA: 413.296.8482
- MD: 240.224.8607
- ME: 207.407.7272

- NC: 919.984.8698
- NH: 603.217.5371
- NJ: 201.581.4521

- NY: 631.250.6020
- OH: 937.871.4594
- PA: 610.273.5998

- SC: 864.973.6279
- VA: 703.202.0499