

Amvuttra (Vutrisiran) Injection Order

Patient Name: _____ DOB: _____ Male Female

Diagnosis (please provide ICD10 code): _____

Other: _____

NKDA Allergies: _____

New Therapy Order Continuation of Therapy Date of last dose: _____

Ordering Provider Name: _____

Provider NPI: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Pre-Medication

- Acetaminophen _____mg by PO
- Ceterizine _____mg by PO
- Diphenhydramine _____mg by PO/ IVP
- Solu-Medrol _____mg by PO/ IVP
- Solu-Cortef _____mg by PO/ IVP
- Other: _____

Required Documentation:

- Patient Demographics
- Patient Insurance (med and pharm card copies, front and back)
- Progress Notes/Labs supporting diagnosis
- Presence of a transthyretin (TTR) gene mutation
- Nerve biopsy which is positive for amyloid deposits
- Other: _____

Patient height and weight:

Patient Height (cm): _____ Patient Weight (kg): _____

Amvuttra Medication Order:

- Dosing
 - 25mg
 - Other: _____
- Frequency
 - Every 3 months
 - Other: _____

Additional Instructions/Notes:

Ordering Provider:

Signature: _____

Date: _____

Provider: _____

Phone: _____ Fax: _____

Best Contact Person in Office: _____

Phone: _____