LIFE SPECIALTY SOLUTIONS

AMVUTTRA
(vutrisiran)

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

DATE OF BIRTH: _____ EMAIL: _____

ALLERGIES: ☐ SEE LIST ☐ NKDA WEIGHT: ☐ LB OR ☐ KG

REQUIRED DOCUMENTATION

1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Most Recent Labs 5. Medication List

PRIMARY DIAGNOSIS

☐ E85.1 Neuropathic hederofamilial amyloidosis

☐ E85.82 Wild-type transthyretin-related (ATTR) amyloidosis

☐ E85.4 Organ-limited amyloidosis

☐ Other _____

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: There are no recommended standard pre-meds for Amvuttra

☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

Amvuttra

☐ Amvuttra 25mg Subcutaneously once every 3 months ☐ Other _____

FIRST DOSE?: ☐ Yes ☐ No ☐ Refill x12 months unless otherwise noted.

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)

☐ Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____

OFFICE CONTACT: _____ FAX: _____

ADDRESS: _____ EMAIL: _____

CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

✖ _____ _____

PROVIDER SIGNATURE DATE