

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 hereditary 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 Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.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: _____

X

PROVIDER SIGNATURE _____ DATE _____