

AMVUTTRA® (vutrisiran)

Patient Information

Full Name: _____ Weight: _____ lbs kg Height: _____
DOB: _____ Allergies: NKDA _____
Phone Number: _____
Patient Status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____


Required Documentation

- | | | |
|--|---|---|
| <input type="checkbox"/> Patient Demographics and Insurance Card | <input type="checkbox"/> Medication List | <input type="checkbox"/> Baseline PND score |
| <input type="checkbox"/> Clinical/Progress Notes Supporting Dx | <input type="checkbox"/> Documentation of a gene TTR mutation | <input type="checkbox"/> Documentation that patient has been instructed to take vitamin A supplementation |
| <input type="checkbox"/> NYHA Class Score | | |

Primary Diagnosis

-  ICD-10 Code (required): _____
- Polyneuropathy of hereditary transthyretin-mediated (hATTR) amyloidosis Other: _____

Therapy Administration

- | | |
|--|---|
| <input type="checkbox"/> Amvuttra 25mg subQ once every 3 months | <input type="checkbox"/> Administer acute infusion and anaphylaxis medications per violet health protocol (see violetinfusions.com/protocol for policy) |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> RN to administer ordered therapy per manufacturer guidelines. |
| Refills: | <input type="checkbox"/> Other: Please fax alternative reaction orders or nursing administration orders if checking this box |
| <input type="checkbox"/> x 1 year <input type="checkbox"/> Other: _____ | |
|  Order valid for one year unless otherwise stated | |

Special Orders

Provider Information

Provider Name: _____ Office Contact Person: _____
Referring Practice Name: _____ Phone Number: _____
Referring Practice Address: _____ Fax Number: _____
City, State, Zip: _____ Email: _____
Provider NPI: _____
Provider Signature: _____ Date: _____