

# 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): \_\_\_\_\_
- |  |   |
|--|---|
| <input type="checkbox"/> Polyneuropathy of hereditary transthyretin-mediated (hATTR) amyloidosis | <input type="checkbox"/> Cardiomyopathy of wild-type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) |
|--|---|

## 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.  |
| <b>Refills:</b>  | <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: \_\_\_\_\_