

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____
 Address: _____ City/ST/Zip: _____
 Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm
Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: Please attach copy of insurance card (front and back).

DIAGNOSIS*

***ICD 10 Code Required** ☐ Neuropathic hereditary amyloidosis, E85.1 ☐ Cardiomyopathy of wtATTR amyloidosis, E85.82
☐ Other: _____, ICD10 _____ ☐ Cardiomyopathy of hATTR amyloidosis, E85.4

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Amvuttra® (vutrisiran)	25 mg	Inject SC once every 3 months x 1 year.

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: _____

Date of last treatment: _____ Date of next treatment: _____

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time
☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO
☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP
☐ Other: _____

LAB ORDERS

Labs to be drawn by Referring Provider.

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____
 Physician Name: _____ NPI: _____ TIN: _____ Specialty: _____
 Address: _____ City/ST/Zip: _____
 Contact Person: _____ Phone #: _____ Fax #: _____
 Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply:

- ☐ Diagnosis is confirmed by detection of a mutation in the transthyretin (TTR) gene? **Please attach copy of test results, if available.**
☐ The patient exhibits clinical signs and symptoms of the disease (e.g., peripheral sensorimotor polyneuropathy, autonomic neuropathy, motor disability, etc.; -or- dyspnea, fatigue, edema, increased ventricular or atrial wall thickness, other hypertrophic features on echocardiography, elevated troponin levels, etc.).
 For neuropathy:
 • Polyneuropathy Disability Score: _____
 For cardiomyopathy:
 • New York Heart Association (NYHA) Functional Class: _____
☐ The patient has not received a liver transplant.

LAB AND TEST RESULTS (required)

☐ TTR genetic test result
☐ EMG/NCV report
☐ Troponin lab results