

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____
Date of Birth: _____ Address: _____
Allergies See List NKDA City, State, Zip: _____
Weight: _____ kg lbs Height: _____ in cm Email: _____

PRIMARY DIAGNOSIS

Cardiomyopathy of wild-type or hereditary transthyretin-mediated amyloidosis (E85.82)

Polyneuropathy of hereditary transthyretin-mediated amyloidosis (E85.1)

Other: _____

PRESCRIPTION

Amvuttra (vutrisiran) 25mg subcutaneously once every 3 months

Other: _____

Has patient received any doses of this medication in the past? Yes No

Refill x 12 months unless otherwise noted: _____

REQUIRED DOCUMENTATION

- Insurance Card
- Patient Demographics
- Most recent labs
- Documentation of gene TTR mutation
- H&P
- Medication List
- Baseline PND Score

ANCILLARY ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS

Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol. (See aiscargroup.com for detailed policy)

Other: Please fax other reaction orders if checking this box

PRE-MEDICATION ORDERS PROTOCOL

Per infusion center protocol: No recommended pre-meds for Amvuttra injection.

Provider Prescribed: _____

LAB ORDERS—PLEASE INCLUDE FREQUENCY

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

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.