

Connecticut
500 W Putnam Ave
Ste 435
Greenwich, CT 06830



VUTRISIRAN

(Amvuttra)

Date: _____

PATIENT INFORMATION

Name:	Phone:	DOB:	SEX: M ☐ F ☐
☐ NKDA Allergies:		Weight lbs/kg:	

PHYSICIAN INFORMATION

Physician Name:	Practice Name:		
Address:	Office Contact Name:	Office Contact #:	
Phone:	Fax:	Email (for updates):	

REFERRAL STATUS

☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ Discontinuation Order

AMVUTTRA: Indication and Usage

- Amvuttra is used to treat polyneuropathy associated with hereditary transthyretin-mediated amyloidosis (hATTR-PN) and cardiomyopathy associated with wild-type or hereditary transthyretin-mediated amyloidosis (ATTR-CM)

- ☒ ICD-10*: E 85.82
- ☐ Dx Code: _____
- ☐ Dx Code: _____
- ☐ Dx Code: _____

PRE-MEDICATION

- ☐ Tylenol PO 650mg ☐ 1000mg ☐ other _____
- ☐ Solumedrol 125mg IV ☐ other _____
- ☐ Benadryl ☐ 25mg ☐ 50mg ☐ other _____ ☐ IV ☐ PO
- ☐ Benadryl 50mg ☐ or PO
- ☐ Medication _____ Dose _____ Route _____
- ☐ _____ (other) ☐ _____ (other)

WARNINGS AND PRECAUTIONS

<https://www.amvuttrahcp.com/sites/default/files/AMVUTTRA-vutrisiran-Prescribing-Information.pdf>

PATIENT WEIGHT

_____ lbs.
_____ kg

AMVUTTRA ORDERS

AMVUTTRA - 25mg/0.5ml SUBQ every 3 months
x _____ refills (3 max)

NOTES/ADDITIONAL COMMENTS:

LAB DRAW REQUEST:

- ☐ Labs: _____
- ☐ Freq: _____

REQUIRED DOCUMENTATION CHECKLIST:

Monitor Vit A levels*

- _____ Patient Demographics
- _____ Insurance Card/Information
- _____ Recent labs
- _____ Recent Progress
- _____ Other

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

Diagnosis Code: _____

Order/dosage: _____

Signature: _____