Amvuttra

Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:
Patient Demographics, Most Recent Office Visit Note Including Neurology Consultation, Insurance Information, hATTR Amyloidosis Labs, EMG Report

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: Patient Phone: DOB:

ICD-10 code (required): ☐ E85.1 ICD Description:

Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

NURSING

- ☑ Center will use Hypersensitivity protocol established by Infusion for Health and PI
- ☑ hATTR Amyloidosis Labs (list results & attach clinicals): _____
- ☑ EMG Results (attach report)

LABORATORY ORDERS

- ☐ CBC ☐ at each dose ☐ every _____
- ☐ CMP ☐ at each dose ☐ every _____
- ☐ Other _____ ☐ every _____
- ☐ Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

PRE-MEDICATION ORDERS

Pre-Medications not usually indicated.

☐ Other: _____

Dose: _____ Route: _____ Frequency: _____

THERAPY ADMINISTRATION

☑ Amvuttra Subcutaneous Injection

Dose: 25mg/0.5 mL

Route: Subcutaenous

Frequency: Once every 3 months

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.

SPECIAL INSTRUCTIONS:

Provider Name (Print) | Provider Signature | Date

☐ ***Please check this box if you DO NOT authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.***