

# Amvuttra (Vutisiran)

**PATIENT INFORMATION**Referral Status (check one):  New Referral  Updated Order  Order Renewal

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

NKDA  Allergies: \_\_\_\_\_ Weight \_\_\_\_\_ Please specify:  lbs  kg Height: \_\_\_\_\_Patient Status (check one):  New to Therapy  Continuing Therapy | Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

ICD-10 code (required): \_\_\_\_\_ ICD-10 description: \_\_\_\_\_

**REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

**PRESCRIPTION****THERAPY ADMINISTRATION** **Vutisiran** (Amvuttra)

- Dose: 25mg
- Route: Subcutaneous
- Frequency: Once every 3 months

 Patient required to stay for 30-min observation post procedure Refills:  Zero /  for 12 months /  \_\_\_\_\_

(if not indicated order will expire one year from date signed.)

**SPECIAL INSTRUCTIONS****PROVIDER INFORMATION**

Referral Coordinator Name: \_\_\_\_\_ Referral Coordinator Email: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

\_\_\_\_\_  
Provider Name (Print)\_\_\_\_\_  
Provider Signature\_\_\_\_\_  
Date**REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK**