

AMVUTTRA Injection Order

Patient Name: _____ DOB: _____ ☐ Male ☐ Female

Diagnosis (please provide ICD10 code) _____

☐ Other: _____

☐ NKDA Allergies: _____

☐ New Start Therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

Ordering Provider: _____

Provider NPI: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

PRE-MEDICATION

- ☐ Acetaminophen 1000mg PO ☐ Solu-Medrol 125mg IVP
☐ Diphenhydramine 25mg PO ☐ Solu-Cortef 100mg IVP
☐ Ceterizine 10mg PO ☐ Diphenhydramine 25mg IVP

REQUIRED LABS

- ☒ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (please attach)

AMVUTTRA ORDERS

DOSING:

- ☐ 25mg SQ injection every 3 months

REFILLS:

☐ _____

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

☒ **Noble Infusion Standing Orders:**

Provide treatment under Noble Infusion's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

Provider Name

Provider Signature

Date