# Amvuttra

## (Vutrisiran injection; SQ)

**PATIENT INFORMATION:**

Patient Name: _____ ☐ Male ☐ Female
DOB: _____ Phone number: _____
Allergies: ☐ NKDA ☐ allergic to _____

**DOSING:**

☐ start new treatment

☐ continue treatment. ____ dose/s already complete. Date of last dose: _____Date of next dose_____

☑ 25 mg/0.5 mL every 3 months for 1 year

**DIAGNOSIS**: Select IDC-10 Code with diagnosis or write your desired code and dx on the line below

☐ E85.1- neuropathic heredofamilial amyloidosis (transthyretin-related familial amyloid polyneuropathy or ATTR-FAP)

☐ E85.4- Organ-limited amyloidosis (which can include cardiac involvement, or ATTR-CM)

☐ E85.82-Wild-type transthyretin-related (ATTR) amyloidosis

other dx:_____ code:_____

**REQUIRED TESTING/CLINICALS- Cardiomyopathy Focused**

☐ pyp (nuclear medicine test) **or** heart biopsy

☐ proof of heart failure (ER visits due to CHF, irregular echo, EKG, and halter monitor trends &/or notes indicating CHF)

☐ genetic testing (to determine hereditary or wild type)

☐ monoclonal antibody to rule out AL (urine and serum)- AKA protein electrophoresis reflex

☐ last clinical note/any notes relevant to dx and process of determining dx- insurance will have to see that cardiomyopathy or neuropathy is not just present but clearly caused by amyloidosis specifically

☐ pt insurance cards, demographics, most recent labs, Rx and allergy list

**ORDERING PROVIDER**:

Ordering Provider: _____
NPI _____
Phone: _____ fax: _____
Practice Address: _____
City: _____ State: _____ Zip: _____

Provider Signature_____ Date: _____

# Amvuttra

**(Vutrisiran injection; SQ)**

NobleInfusion
Phone: 386-957-9600
Fax: 386-957-9400