Vutrisiran (Amvuttra)

Provider Order Form rev. 08/25/2025

PATIENT INFORMATION **Referral Status:** ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS ***(Please provide ICD-10 code in space provided)***

Polyneuropathy of hereditary transthyretin-medicated amyloidosis:

Cardiomyopathy of wild-type or hereditary transthyretin-mediated amyloidosis:

Other: Description:

THERAPY ADMINISTRATION

☑ Administer Amvuttra 25mg subcutaneously every 3 months

ADDITIONAL ORDERS

LABORATORY ORDERS

☐ Other: _____

PRE-MEDICATION ORDERS

☐ Other: _____

NURSING

☑ Hold infusion and notify provider if the patient is having ocular symptoms.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

☑ Continue Vitamin A supplements if prescribed by doctor

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECK LIST ***(Additional documentation required for processing and insurance approval)***

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, Supporting documentation of the diagnosis of hereditary transthyretin-mediated (hATTR) amyloidosis.

Provider Name ***(print)*** **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.