Provider Order Form

AMVUTTRA (VUTRISIRAN)

Uptiv Health

PATIENT

Full Name: DOB:

Mobile Phone: Weight: ☐ lbs ☐ kg

Allergies: ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: Next Treatment Date:

DIAGNOSIS ICD-10 code (must be specified)

☐ Neuropathic heredofamilial amyloidosis E85.1 ☐ Other: _____

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

PROVIDER

Provider Name: Provider NPI:

Practice Name: Referral Coordinator Name:

Practice Address:

Phone: Fax: Email:

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☒ AMVUTTRA (vutrisiran), Subcutaneous Injection	☒ 25 mg	☒ 25 mg administered by subcutaneously once every 3 months.

Other:

Refills ☐ Zero ☐ 12 months ☐ _____ Order valid for 1 year unless otherwise stated. _____

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance Card ☐ Progress Notes Supporting DX ☐ Tests supporting primary diagnosis

Provider Signature Date