REVITALIZE
INFUSION CENTER

AMVUTTRA®

Infusion Order Form

Patient Information:

_____ _____ _____

Patient Name **DOB** **Phone Number**

Medical Information:

Primary Diagnosis:

☐ Neuropathic heredofamilial amyloidosis ICD-10 Code: E85.1

☐ Organ-limited amyloidosis ICD-10 Code: E85.4

☐ Wild-type transthyretin-related (ATTR) amyloidosis ICD-10 Code: E85.82

☐ Other_____ ICD-10 Code: _____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Relevant labs and tests
- Required Information:
  - Documentation of TTR mutation
  - Medication list including confirmation that the patient has been instructed to take Vitamin A

Height: _____

Weight: _____

Orders:

Amvuttra (vutrisiran)

Administer 25 mg subcutaneously every ☐ 3 months ☐ Other:_____

Doses Authorized for:

☐ 6 months (2 doses) ☐12 months (4 doses) ☐ Other: _____ months (_____ doses)

Pre-Medication Orders:_____

*No pre-medications are recommended based on the manufacturer's PI

Lab Orders:_____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____ _____

Prescriber's Signature **Date**

_____ _____

Prescriber's Printed Name **Contact Phone #:**

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize Revitalize Locations InfusionPlus