

# Infusion Order Form

**Patient Information:**

\_\_\_\_\_  
**Patient Name** **DOB** **Phone Number**

**Medical Information:**

Primary Diagnosis:

- |   |                     |
|---|---------------------|
| <input type="checkbox"/> Neuropathic hereditary amyloidosis                 | ICD-10 Code: E85.1  |
| <input type="checkbox"/> Organ-limited amyloidosis                          | ICD-10 Code: E85.4  |
| <input type="checkbox"/> Wild-type transthyretin-related (ATTR) amyloidosis | ICD-10 Code: E85.82 |
| <input type="checkbox"/> 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 its 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 #:**

Please fax the completed order form and all other requested information to: 601-714-1569

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



Revitalize



Revitalize Locations



InfusionPlus