# AMVUTTRA® (vutrisiran) Referral Form

BIOHEALTH INFUSION CENTER

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## PATIENT INFORMATION

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

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

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

ICD-10 code (required): ICD-10 description: Last Treatment Date: Last 4 SSN:

## PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

### NURSING

☑ Infusion to be administered per BioHealth protocols.

### LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ OTHER

### PREMEDICATIONS

☐ acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

### AMVUTTRA THERAPY ADMINISTRATION

☐ 25 mg subcutaneous every 3 months x 1 year

### REQUIRED DOCUMENTATION

☐ **Patient Demographics**
☐ **Insurance Card/Information**
☐ **Progress Notes Supporting DX**
☐ **Current Medication List and H&P**
☐ **Baseline PND Score**
☐ **Documentation of a gene TTR mutation**
☐ **Patient is taking Vitamin A**
☐ **Patient has not had a liver transplant**

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions **Order is valid for one year unless otherwise noted**.

**Provider Name (Print)** **Provider Signature** **Date**

**Have a Question? (786)460-6044**
**Fax Referral Form To: (786)219-3917**
**8684 SUNSET DRIVE MIAMI FL 33143**