Your Health, True Wealth

AMVUTTRA® (vutrisiran) Referral Form

Please send the following with clinical documentation, which includes visit, physical and history notes, plus lab results for last 3 months, to:
f: 818-882-8929

PATIENT INFORMATION

Patient Name		DOB	Contact Phone
Address	City	State	Zip
Gender ☐M ☐F	Social Security, last 4 digits	Weight (lb.)	Height (in.)
☐ NKDA	☐Allergies		
ICD-10 code (required)		ICD-10 description	
Patient Status ☐New to Therapy ☐Continuing Therapy			

PRESCRIBER INFORMATION

Ordering Prescriber Practice		Prescriber NPI	
Name		Phone	Fax
Practice Address	City	State	Zip

REQUIRED DOCUMENTATION

☐Insurance Cards ☐History & Physical ☐Most Recent Labs ☐Medication List

AMVUTTRA TREATMENT PLAN

AMVUTTRA injection for subcutaneous use, 25 mg/0.5 ml

☐ 25 mg via subcutaneous injection once every 3 months

- Quantity: one (1) prefilled syringe

Refills: ☐ Refill x3 ☐ Other:

List or attach a list of concomitant medications and any special instructions:

ANCILLARY ORDERS

Anaphylaxis Kit Does this patient require an anaphylaxis kit? ☐ Yes, with 1st dose ☐ Yes, with all doses

- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SubQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.

NURSING

Skilled RN to establish and maintain vascular access as needed, draw ordered labs, conduct patient assessments, and educate on home infusion, medi- cation administration, self-monitoring and safety.

PREMEDICATION

☐ Include premedication per Northridge Pharmacy Specialty & Infusion's infusion protocol.

☐ Other _____

LABORATORY ORDERS

☐ CBC every _____
☐ CMP every _____
☐ Other

I authorize the above patient treatment and Northridge Pharmacy Specialty & Infusion to serve as my agent when investigating and seeking approval of coverage and benefits for the Patient's services included in this form, including all site of service options and patient financial responsibility amounts. Such information may be provided to Northridge Pharmacy Specialty & Infusion at fax: 818-882-8929

Prescriber Name (Print) _____ Prescriber Signature _____ Date _____