



Checklist for Amvuttra (vutrisiran) Referral

Patient Name: _____ DOB: _____ Date: _____

Referring Physician: _____ NPI: _____

Office Contact/Title/Email: _____

Office Address: _____

Office Phone: _____ Office Fax: _____

Best contact number for physician in case of reaction: _____

Please return completed checklist and checklist items to initiate referral. Use this form as fax cover sheet.

- ☐ Patient demographic information
- ☐ Insurance information and copy of insurance card/s (front and back). *Include primary and secondary insurance
- ☐ Supporting clinical notes and office visits. Two notes preferred.
 - Note should include any therapies tried/failed, and must include discussion about Amvuttra
 - Medication list and allergies
- ☐ Supporting lab reports/imaging for Amvuttra treatment
 - hATTR-PN or ATTR-CM diagnostic results
- ☐ Amvuttra Prescribing Order (see attached)

-- We will obtain prior authorization and schedule your patient as soon as possible --

Fax all information to our Infusion Coordinator: 508-698-8671

Call with any questions: 781-551-5812 option 4

Visit our website: www.InfusionCenterNE.com

Email: info@infusioncenterne.com

Infusion Center of New England

18 Washington Street, Foxboro MA 02035

Ph: 781-551-5812

Fax: 508-698-8671



Prescribing Order: Amvuttra (vutrisiran)

Date of Order: _____

☐ New Start

☐ Maintenance

Date of last injection: _____

Patient Name: _____ DOB: _____ M/F: _____

Diagnosis (include ICD-10 code/s): _____

☐ NKDA Allergies: _____

Premedication:

☐ Acetaminophen 1000mg PO

☐ Diphenhydramine 25mg PO

☐ Loratadine 10mg or Cetirizine 10mg PO

☐ Other: _____

Medication Order

☐ Amvuttra 25mg/0.5ml SQ every 3 months

☐ Other: _____

Administration:

✓ Administer Amvuttra as a subcutaneous injection in the thigh, abdomen, or upper arm

✓ In case of reaction, follow NCNE infusion reaction protocol. Notify physician.

Ordering Provider Name

NPI

Signature

Date

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