MRN:_____

Phone: 1-800-809-1265 Fax: 1-866-872-8920

DOB: _____

Standard Plan of Treatment for AMVUTTRA™(Vutrisiran)

NOTE: *We may require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for this treatment through Medicare and/or other insurance plans.*

1. **Patient Name**: _____Height(in.):_____
2. **Allergies**:_____
3. **Diagnosis:**

☐ E85.1 Neuropathic Heredofamilial Amyloidosis

☐ Other **ICD-10 Code:** _____ Diagnosis description: _____

4. Dose:

☐ **Administer AMVUTTRA™ 25mg/0.5ml via Subcutaneous Injection every 3 months**

Administer subcutaneously into the abdomen, upper arm, or thigh

Special Orders: _____

_____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

5. Physician's Signature: _____/_____ **Date**: _____

(Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials: _____ NPI: _____

8. ***Fax updated supporting clinical MD notes with each order renewal or change in orders***

Infusion order forms and Adverse Drug Reaction Guidelines are available at www.palmettoinfusion.com

Revised: 06/17/22

MRN:_____
DOB: _____

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Guidelines for Prescribing

(Required documentation with all initial referrals)

Patient Name: _____ Referral Date: _____

☐ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-8)*
(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

☐ Include patient demographic information and insurance information. (Copy of insurance cards if available)

☐ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.**

- AMVUTTRA™ is indicated for the treatment of the polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults.

☐ Inform patients that AMVUTTRA™ treatment leads to a decrease in vitamin A levels measured in the serum. Instruct patients to take the recommended daily allowance (RDA) of vitamin A. Higher doses than the RDA should not be given to achieve normal serum vitamin A levels during treatment, as serum levels do not reflect the total vitamin A in the body.

☐ Other as requested: _____
_____
_____
_____

AccuRx Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.