Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Amvuttra™ (vutrisiran) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:								
Date of Referral:				Patient's Phone:				
Patient Name:				Address:				
Date of Birth:				City, State, Zip:				
Height in inches:	Weight:	LB or	KG	Gender:	Allergies:	☐	See list	☐ NDKA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

- ☐ E85.1 - Neuropathic Heredofamilial Amyloidosis
- ☐ _____ - Other:_____

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INJECTION DATE:
3	Full medication list		NEXT INJECTION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	Lab results and/or tests supporting primary diagnosis		☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

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. 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.

DOSE/FREQUENCY:

☑ **Amvuttra™**: Administer 25mg/0.5ml via subcutaneous injection every 3 months into the abdomen, upper arm, or thigh.

SPECIAL ORDERS:

☐ _____

_____

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:	ADVERSE REACTION & ANAPHYLAXIS ORDERS:
☑ Start PIV/Access CVC ☑ Flush device per facility standard flushing procedure	Administer acute infusion and anaphylaxis medications per Palmetto Infusion/AccuRX standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:	
PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE
Dispense as written/Brand medically necessary	Substitution permitted	

ACCURX
INFUSION CENTER
A PALMETTO INFUSION COMPANY

Checklist for referrals to AccuRX Infusion:

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**

Palmetto 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. AccuRX Infusion Call Center 888.410.0317. Thank you for the referral.

www.AccuRXInfusion.com

02/08/2023