

AMVUTTRA® (VUTRISIRAN) PRESCRIBER ORDER FORM

Patient Name:

Date of Birth:

Address:

Phone:

Height:

 inches cm

Weight:

 lbs kg**Clinical Information**

Primary Diagnosis Description:

 Hereditary Transthyretin Amyloidosis E85.82 Cardiomyopathy unspecified I42.9 Other _____**Prescription****AMVUTTRA 25mg/0.5mL single dose prefilled syringe**

25mg administered by subcutaneous injection once every 3 months by a healthcare professional

Refill as directed x 1 year

Ancillary Orders**Anaphylaxis Kit**If this is a 1st infusion dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose? Yes No**Dosage:**

- 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.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Skilled nursing to establish peripheral IV access as needed to manage anaphylaxis.

Medication Orders _____**Lab Orders** No labs ordered at this time. Other: _____

Skilled nurse to assess and administer via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____

Date: _____

Prescriber Information

Prescriber Name:

Phone:

Fax:

Address:

NPI:

City, State:

Zip:

Office Contact:

Fax completed form, insurance information, and clinical documentation to:

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