Agile Infusion Services LLC
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AMVUTTRA MEDICATION ORDER

Patient's Name (Last, First, Middle) ___________________________ DOB ______________________

Patient's height in feet and inches ____________________ *Patient's weight in pounds* _________________________

■ Diagnosis

☐ E85.1 HATTR amyloidosis with polyneuropathy ☐ Other: _________________________________

■ Details Needed for Approval *Please answer all questions and provide supporting documentation.*

- Does the patient have a definitive diagnosis of hATTR? _______
- Does the patient have peripheral sensorimotor polyneuropathy? _______
- Does the patient have autonomic neuropathy symptoms? _______
- Does the patient have abnormal neurologic exam suggestive of neuropathy? _______
- Will the patient use Amvuttra in combination with Tegsedi, Vyndamax, Vyndaqel or Onpattro? _______
- Has the patient been the recipient of an orthotopic liver transplant? _______
- Has the patient been instructed to take a daily vitamin A supplement? _______
- Please provide the following documentation:
  - Definitive hATTR diagnostic testing including genetic results.
  - Abnormal nerve conduction results consistent with polyneuropathy.
  - Chart notes which include exclusion of other causes of neuropathy.
  - Baseline strength/weakness tests via objective tool such as MRC.
  - Baseline PND score.
  - Comprehensive chart notes including patient's medication list and recent laboratory results.
  - If applicable, last date of administration of alternate hATTR agent.

■ Medication Order

☐ Amvuttra (vutrisiran) 25mg injected subcutaneously every 3 months for 1 year.

■ Rescue Management in Case of Reaction

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.
- Call ordering provider to report reaction.

■ Ordering Provider Authorization

Provider Signature: ___________________________ Name: _________________ Date: ____________________

Address: ____

Phone: ________________ Fax: _________________ Indiv. NPI #: ____________ License: ________________

Best Contact Person in Office: _______________________ Direct Phone to Contact Person: ___________________

Documentation to Include:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.

FAX THIS ORDER AND SUPPORTING DOCUMENTATION TO 201-266-0437 OR UPLOAD USING YOUR SECURE DEDICATED WEBPAGE – TO GET A PERSONAL LINK PLEASE CONTACT THE INTAKE TEAM.