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
☐ E85.82 Wild-type ATTR amyloidosis
☐ E85.4 Organ-limited ATTR familial cardiomyopathy
☐ Other: _____

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

For all patients

- Will the patient use Amvuttra in combination with Wainua, 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 comprehensive chart notes, lab & scan results and, if applicable, date of last administration of prior therapy for this condition.

Amyloidosis with polyneuropathy

- 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? _____
- Who is patient's neurologist? _____ Phone: _____
- Please provide the following documentation:
  - Definitive hATTR diagnostic testing including genetic results.
  - Abnormal nerve conduction results consistent with polyneuropathy, and notes excluding other causes.
  - Baseline strength/weakness tests via objective tool such as MRC. Baseline PND and FAP scores.

Amyloidosis with cardiomyopathy

- Does the patient have a definitive diagnosis of cardiac ATTR with cardiomyopathy? _____
- Insurance authorization requirements for this new indication are evolving; necessary documentation may change.

■ **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.