

Vutrisiran (Amvuttra)

Provider Order Form rev. 8/23/26



PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____ Mobile Phone Number: _____
Weight (lbs/kg): ☐ NKDA Allergies: _____
Therapy Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

REQUIRED SUPPORTING DOCUMENTATION *(Please include the following with the order to support processing & insurance approval)*

• Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)

DIAGNOSIS ICD-10 CODE *(Provider must specify)*

- ☐ E85.1 Polyneuropathy of Hereditary Transthyretin-mediated Amyloidosis
☐ E85.82 Cardiomyopathy of Wild-type or Hereditary Transthyretin-mediated Amyloidosis
☐ Other: _____

PRIMARY MEDICATION ORDER

Amvuttra 25mg subcutaneous injection every 3 months

• Refill for 12 months unless otherwise noted: _____

SPECIAL INSTRUCTIONS

PRE-MEDICATION

Note: pre-meds not typically indicated for Amvuttra

☐ Other: _____
Dose: _____ Route: _____

NURSING

- Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

Ordering Provider (Print) _____ Provider Signature _____ Provider NPI _____ Date _____

☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zipcode: _____

ARBOR INFUSION FAX NUMBERS *(Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)*

- ☐ Arbor Infusion Fishers (317) 981-1772