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AMVUTTRA (vutrisiran)

PATIENT DEMOGRAPHICS

Patient Name: _____
Date of Birth: _____ M: ☐ F: ☐ Address: _____
Phone: _____ City, State, Zip: _____
Email: _____

Allergies: _____

PRIMARY DIAGNOSIS

ICD-10 Code: _____

DOCUMENTATION (PLEASE ATTACH)

Clinical / Progress Notes, Labs, Tests supporting primary diagnosis

Clearwell Infusion Centers will draw maintenance labs unless otherwise directed by Referring Provider

PRE-MEDICATION

- | | |
|--|---|
| <input type="checkbox"/> Acetaminophen 1000mg PO | <input type="checkbox"/> Solu-Medrol 125mg IVP |
| <input type="checkbox"/> Diphenhydramine 25mg PO | <input type="checkbox"/> Solu-Cortef 100mg IVP |
| <input type="checkbox"/> Ceterizine 10mg PO | <input type="checkbox"/> Diphenhydramine 25mg IVP |
| <input type="checkbox"/> Loratadine 10mg PO | <input type="checkbox"/> Other: _____ |

PRIMARY MEDICATION ORDER

Dosage

- ☐ AMVUTTRA (vutrisiran) 25 mg subcutaneous injection

Patient Weight: _____

lbs

kg

Frequency

- ☐ Once every 3 months

NOTES

ORDERING PROVIDER

Provider Name: _____	NPI: _____
Practice Name: _____	Phone: _____
Office Contact: _____	Fax: _____
Practice Address: _____	
City, State, Zip: _____	

Provider Signature: _____

Date: _____