



Phone: (305)306-7147
Fax: (305)402-9559
Email: intake@clearwellinfusion.com

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: _____