AMVUTTRA® (vutrisiran) Referral Form

Preferred Clinic (select one):

PATIENT INFORMATION

Referral Status: New Referral Updated Referral Referral Renewal

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

NKDA Allergies: Weight (lbs/kg): Height:

ICD-10 Code (required): ICD-10 Description: Last Treatment Date: Last 4 Digits SSN:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

Physician Preferred Method of Contact: Email: Fax: Phone:

NURSING

☑ Infusion to be administered per Vivo protocols.

REQUIRED DOCUMENTATION

- **Patient Demographics**
- **Insurance Card/Information**
- **Progress Notes Supporting DX**
- **Current Medication List and H&P**
- **Baseline PND Score (if available)**
- **Documentation of a gene TTR mutation**
- **Patient is taking Vitamin A**
- **Patient has not had a liver transplant**
- **Diagnostic testing to confirm neuropathy *for hATTR-PN only**

AMVUTTRA THERAPY ADMINISTRATION

25 mg subcutaneous every 3 months x 1 year

Order is valid for one year unless otherwise noted

Provider Name (Print) **Provider Signature** **Date**

Email Referrals To: referrals@vivoinfusion.com OR Fax Below

Have a Question? Call (720) 902-4111

Colorado: 303-418-4679	Michigan: 833-957-2188	New York: 800-540-1852	Texas: 469-340-0044
Connecticut: 203-724-4838	Minnesota: 763-290-0903	Ohio: 216-400-0674	Virginia: 804-500-5941
Florida: 904-930-4211	Nevada: 702-489-5744	Oklahoma: 918-770-4421	Wisconsin: 414-600-5383
Massachusetts: 781-202-1629	New Jersey: 609-955-3711	Pennsylvania: 215-399-9244	