

AMVUTTRA® (vutrisiran) Referral Form



Preferred Clinic (select one):

PATIENT INFORMATION

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:

STANDING ORDER

☒ 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 (if applicable)
- Patient is taking Vitamin A
- Patient has not had a liver transplant
- Diagnostic testing to confirm neuropathy *for hATTR-PN only

AMVUTTRA ADMINISTRATION

25 mg subcutaneous every 3 months x 1 year

DIAGNOSIS (Select One):

- E85.1 Neuropathic hereditary amyloidosis
- E85.82 Wild-type transthyretin-related (ATTR) amyloidosis
- E85.4 Organ-limited amyloidosis

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

Revision Date 12/2025