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 (kg): Height:

ICD-10 Code (required): ICD-10 Description: Last Injection 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 heredofamilial amyloidosis

☐ E85.82 Wild-type transthyretin-related (ATTR) amyloidosis

☐ E85.4 Organ-limited amyloidosis

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

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