amvuttra (vutrisiran) injection 25 mg/0.5 mL

Horizon Infusions

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to (315) 457-4305

Phone (315) 457-3091

1. PATIENT INFORMATION

Name:	**DOB:**
Phone:	**Other Phone:**
Email:	
Social Security #:	**Allergies:**
Gender: ☐ M ☐ F	**Weight:** ☐ Lbs ☐ Kg

Patient Status: ☐ New to therapy ☐ Continuing therapy ☐ Next due date ***(if applicable)***:

2. INSURANCE INFORMATION (*required*)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name:		**NPI#:**
License #:	**TIN#:**	**DEA#:**
Address:		
City:		**State** **Zip**
Office Contact:		**Email:**
Office phone:		**Office fax:**

4 . DIAGNOSIS and ICD 10 CODE

☐ **Neuropathic heredofamilial amyloidosis** **E85.1**

5. PRESCRIPTION INFORMATION (*requires new order every 12 months*)

AMVUTTRA

☐ **25mg Sub-Q once every 3 months**

☐ **Vital signs per HI Protocol**

☐ **Anaphylaxis & Hydration Management per HI Protocol**

PRE-MEDICATIONS ☐ **N/A**

☐ **Acetaminophen** ☐ **500mg** ☐ **650mg** ☐ **1000mg**

☐ **Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)**

☐ **Diphenhydrimine (Benadryl)** ☐ **25mg** ☐ **50mg** ☐ **PO** ☐ **IV** (requires driver)

☐ **Methylprednisolone (Solu-Medrol)** ☐ **40mg** ☐ **80mg** ☐ **125mg IV**

☐ **Prednisone _____ mg PO**

☐ **Other _____**

POST-MEDICATIONS ☐ **N/A**

☐ **Acetaminophen** ☐ **500mg** ☐ **650mg** ☐ **1000mg**

☐ **Prednisone _____ mg PO**

☐ **Other _____**

6. LABS

☐ **CBC w/Diff**	☐ **Each Infusion**	☐ **Other Frequency (*specify*): _____**
☐ **CRP**	☐ **Each Infusion**	☐ **Other Frequency (*specify*): _____**
☐ **CMP**	☐ **Each Infusion**	☐ **Other Frequency (*specify*): _____**
☐ **ESR**	☐ **Each Infusion**	☐ **Other Frequency (*specify*): _____**
☐ **Hepatic Panel**	☐ **Each Infusion**	☐ **Other Frequency (*specify*): _____**
☐ **Renal Panel**	☐ **Each Infusion**	☐ **Other Frequency (*specify*): _____**

☐ **Quantiferon TB Gold, annually, last completed *(date)*: _____**

☐ **Other (*specify*):_____**

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE **DATE**