



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 Organ-limited amyloidosis E85.4

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

#### 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)

Diphenhydramine (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