

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 hereditary 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