SPECIALTY INFUSION CENTER
An Access Infusion Care Company

VUTISIRAN ORDERS (Amvuttra)

CENTERS AT SIC
An Access Infusion Care Managed Company

REFERRAL CHECKLIST
Please ensure the following information is included with your referral:
☐ Patient Demographics and Contact Information
☐ Patient Insurance Information
☐ Completed H&P and Progress Notes Including Medications and Allergies
☐ Recent Lab Results/Testing/Screenings Supporting the Diagnosis
☐ Completed and Signed Referral
☐ Cardiac Testing results (PYP scan, ECHO-if available)
Dx Codes: E85.4 Organ-limited amyloidosis E85.1 Neuropathic heredofamilial amyloidosis E85.82 Wild-type transthyretin-related (ATTR) amyloidosis
Including this information will minimize delays with prior authorizations and ensure timely treatment for your patient. Thank you!

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Print, complete, and fax completed form to (855) 857-3834

VUTISIRAN ORDERS (Amvuttra)

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI:
City, State, Zip:	Address:
Cell: Email:	City, State, Zip:
Ht: Wt: kg Last 4 of SSN: DOB:	Phone: Fax:
Allergies:	Contact Person:

REFERRAL STATUS ☐ New Referral ☐ Continuation Order ☐ Dose or Frequency Change

First dose? ☐ Yes ☐ No - Date of last injection:

DIAGNOSIS

Dx code and description:

REQUIRED DOCUMENTATION ☐ Signed order ☐ Demographics/insurance info ☐ H&P/labs/tests/progress notes supporting the Dx

☐ Monoclonal Protein levels	☐ Ensure patient is taking Vitamin A supplementation
☐ Cardiac PYP Scan	☐ Echocardiogram (if available)

Prior Therapies:

PRESCRIBING INFORMATION

LAB ORDERS

Frequency: Every Labs: ☐ CMP ☐ CBC w dif ☐ Other:

MEDICATION

Medication	Strength	Dose/Directions	Quantity
☒ **Vutisiran (Amvuttra)**	25mg/0.5mL	☒ 25 mg – Inject subcutaneously every 3 months	1 PFS Refills:

If not specified, order will be valid for 1 year from the date of signature.

OBSERVATION

Observe the patient for at least 30 minutes after the first infusion, no observation for subsequent infusions if no IRRs

NURSING INSTRUCTIONS/EMERGENCY MEDICATION

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines Post-Infusion:50ml0.9%NS to flush residual priming volume	PIV:Flush 3-10mL0.9%NS before/after PICC/Midline/Port:Flush 10mL0.9%NS before/after, then 3mLHeparin 10u/mL(PICC/Midline)/5mLHeparin 100u/mL(Port)final

Administer the following medications as needed for infusion-related reactions per company protocol:
Adults>40kg: Diphenhydramine25-50mgPO or IVP(2-5min); Acetaminophen325-650mgPO; Methylprednisolone125mgIVP(≥5min); Epinephrine0.3mgIM/SQ, may repeat×1; 0.9%NS500mLIV over 30-60 min, may repeat×1 for hypotension.
Pediatrics/Adults<40kg: Diphenhydramine25mgPO or IVP(2-5min); Acetaminophen325mgPO; Methylprednisolone40mgIVP(≥5min); Epinephrine0.15mg(<30kg)/0.3mg(>30kg)IM/SQ, may repeat×1; 0.9%NS500mLIV over 30-60min, may repeat×1 for hypotension.
Oxygen(AIC/AIS only):1-6L/min via NC/face mask; titrate to maintain $SpO_2$95-100%.

Prescriber Signature X: _____ **Date:** _____

☐ **Product Substitution Permitted** ☐ **Dispense as Written**

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