INTRAMED Plus
infusion services

AMVUTTRA®

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD-10 Code):

Primary Diagnosis:

_____ Neuropathic heredofamilial amyloidosis — ICD-10 Code: E85.1

_____ Wild-type transthyretin-related (ATTR) amyloidosis — ICD-10 Code: E85.82

_____ Organ-limited amyloidosis — ICD-10 Code: E85.4

_____ Other: _____ — ICD-10 Code: _____

Allergies: _____ (or attach list)

3. Clinical Information — Please fax with Infusion Order Form:

Patient
Weight: _____ lbs.
Height _____ in.

- Clinical documentation supporting primary diagnosis
- Recent Lab/Test Results including:
  - o Documentation of a gene TTR mutation
- Medication List
  - o Patient has been instructed to take vitamin A supplementation

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AMVUTTRA® (vutrisiran) J Code: J0225

4. Drug Order:

Administer 25 mg/0.5 mL by subcutaneous injection once every 3 months

Doses authorized: 4 (four)

Pre-Medication Orders: _____

No premedication or laboratory monitoring are required per manufacturer

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.
By signing this form and utilizing our services, I am authorizing Intramed Plus

to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____

Dispense as written — Substitution permitted

Printed Physician's Name with Credentials: _____ Phone #: _____

FAX ALL INFORMATION	CENTRAL INTAKE PHONE
CENTRAL FAX **803.999.1754**	**803.999.1750**