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
_____ Cardiomyopathy of Wild-type transthyretin-related (ATTR) amyloidosis — ICD-10 Code: E85.82
_____ Cardiomyopathy of Organ-limited amyloidosis — ICD-10 Code: E85.4
_____ Cardiomyopathy unspecified — ICD-10 Code: I42.9
_____ Other: _____ — ICD-10 Code: _____

Allergies: _____ (or attach list)

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

- Clinical documentation supporting primary diagnosis
- Recent Lab/Confirmation of diagnosis test results:
  - o Genetic testing, tissue biopsy testing, and/or diagnostic imaging as appropriate
- Medication List
  - o Patient has been instructed to take vitamin A supplementation

Patient
Weight: _____ lbs.
Height _____ in.

4. Drug Order: AMVUTTRA® (vutrisiran)

J Code: J0225

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

Doses authorized: 4 (four)

Skilled nurse to administer doses by the ordered route (IV or SUBQ). For SUBQ administration, nurse to assess, administer, and provide ongoing support as needed.

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.
Anaphylaxis Kit:

- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

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**	**803.999.1760**	Access Intramed Plus prescription order forms here.

MAY 2026