AMVUTTRA (VUTRISIRAN) ORDER FORM

P: 240.200.4464 F: 240.892.3005

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 240.892.3005

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐New to Therapy ☐Continuing Therapy **Next Treatment Date:** _____

MEDICAL INFORMATION

Patient Weight: _____ lbs./kg. (required) Allergies: _____

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:** _____

THERAPY ORDER

AMVUTTRA (vutrisiran)

- ☐ 25 mg subcutaneously once every 3 months x 1 year
- ☐ Other: _____

Please provide the patient's demographic information, insurance information, medication list, and clinical notes. Active Infusions will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

PROVIDER INFORMATION

Provider Name: _____ Signature: _____

Provider NPI: _____ Phone: _____ Fax: _____

Contact Person: _____ Date: _____

ACTIVE infusions

COMPREHENSIVE SUPPORT FOR AMVUTTRA THERAPY

P: 240-200-4464 F: 240-892-3005

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete previous page)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's mediation list
- ☐ Supporting clinical notes (H&P) to support primary diagnosis including:
  - ☐ Documentation of a gene TTR mutation
  - ☐ Please indication New York Heart Association Class (NYHA):
    - ☐ I
    - ☐ II
    - ☐ III
    - ☐ IV
  - ☐ For *polyneuropathy diagnosis* (please answer):
    - ☐ Baseline polyneuropathy disability (PND) score: _____
    - ☐ Baseline familial amyloid polyneuropathy (FAP) stage: _____
- ☐ Patient has been instructed to take Vitamin A supplementation
- ☐ Other medical necessity: _____

Please fax all information to 240-892-3005 or email to info@activeinfusions.com for assistance