



LivWell
INFUSIONS

Amyvuttra Injection Order

Fax 888 511-7654 Phone 888 864-7341

Patient Name: _____

DOB: _____

Patient Phone: _____

SEX: M ☐ F ☐

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis: ☐ E85.1 Polyneuropathy of hATTR amyloidosis
☐ E85.82 Cardiomyopathy of wtATTR amyloidosis
E85.4 Cardiomyopathy of hATTR amyloidosis

Patients weight: _____

Lab Date: _____

Allergies: _____

ICD-10 _____

ALSO INCLUDE...

- ☐ Clinical/ Progress Notes
- ☐ Demographics Sheet
- ☐ Current Medications
- Labs

AMVUTTRA ORDER

Amyvuttra Dose: ☐ Administer 25mg via Subcutaneous Injection every 3 months for 1 year

Date of last Amyvuttra Injection: _____

Yes No Patient is currently taking Vitamin A Supplements

Yes No Patient has not had a liver transplant

Yes No Diagnostic testing confirms neuropathy (for hATTR-PN only)

Baseline PND Score: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____

Phone: _____

Practice Address: _____

Office Contact: _____

Fax: _____

NPI/ TIN: _____

Referring Physician's Signature _____

Date: _____