Amvuttra Injection Order

LivWell INFUSIONS

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:

◯ E85.82 Cardiomyopathy of wtATTR amyloidosis

◯ E85.4 Cardiomyopathy of hATTR amyloidosis

◯ E85.1 Polyneuropathy of hATTR amyloidosis

ICD-10 _____

Patients weight: _____

Lab Date: _____

Allergies: _____

ALSO INCLUDE...

◯ Clinical/ Progress Notes

◯ Demographics Sheet

◯ Current Medications

◯ Labs

AMVUTTRA ORDER

Amvuttra Dose: ◯ Administer 25mg via Subcutaneous Injection every 3 months for 1 year

Date of last Amvuttra 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: _____

* Only required with E85.1

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____