



Patient Name: _____
Patient Phone: _____

DOB: _____
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
Other: _____
ICD-10 _____

ALSO INCLUDE...

- Clinical/ Progress Notes
- Insurance Cards
- 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: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ Phone: _____

Practice Address: _____

Office Contact: _____ Fax: _____

NPI/ TIN: _____

Referring Physician's Signature _____ Date: _____