Wainua 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: ◯ E85.1 Polyneuropathy of hATTR amyloidosis

◯ Other:

ICD-10 _____

ALSO INCLUDE...

- Clinical/ Progress Notes
- Insurance Cards
- Demographics Sheet
- Current Medications
- Labs

WAINUA ORDER

Waiuna Dose: ◯ Administer 45mg via Subcutaneous Injection once monthly for 1 year

Date of last Wainua 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:** _____