



A Carelon Company

AMVUTTRA (VUTRISIRAN) INJECTION ORDERS

P: 877-365-5566 | F: 855-889-2946

PATIENT INFORMATION Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Address:		City:	State:	ZIP:
Phone:	Email:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg
Allergies:				

Diagnosis Code ICD-10: (required)	Diagnosis Description:
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy	Next Treatment Date:

PHYSICIAN INFORMATION

Prescriber Name:		Phone:	Fax:
Office Contact:		Email:	
Address:		City:	State: ZIP:
NPI #:	DEA#	Tax ID:	

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Medication Orders	Refills
Amvuttra (vutrisiran): <input type="checkbox"/> 25mg SUBQ once every 3 months	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____

Other orders: _____

Lab orders: _____ Lab Frequency: _____

As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution.	<input type="checkbox"/> Dispense as written
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PRESCRIBER SIGNATURE By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

X:	Date:
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PATIENT INFORMATION

Name:

DOB:

REQUIRED DOCUMENTATION FOR REFERRAL CROSSING & INSURANCE APPROVAL

- Include signed and completed order (MD/prescriber to complete page 1)
- Include patient demographic information and insurance information
- Include patient's current medication list
- Supporting clinical notes (H&P) to support primary diagnosis - Including
 - Documentation of gene TTR mutation
 - Please indicate 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: _____