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: ☐ Female ☐ Male
Address:		City: State:	ZIP:
Phone:	Email:	Height: ☐ inches ☐ cm	Weight: ☐ lbs. ☐ kg
Allergies:			
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**	
Patient Status: ☐ New to Therapy ☐ 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)

Drug	Dosing	Refills
Amvuttra (vutrisiran)	☐ 25mg SubQ once every 3 months	☐ x 1 year ☐ ________

Other orders: ____

Lab orders: ______________________ Lab Frequency: ______________

As required by your state, Prescriber to check “Dispense as written” or handwrite “Brand Medically Necessary” and sign to prevent generic substitution.

☐ Dispense as written

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.

Prescriber Signature X:	**Date:**

COMPREHENSIVE SUPPORT FOR AMVUTTRA THERAPY

PATIENT INFORMATION

Name: DOB:

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & 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: ____