BIG SKY IV CARE
An Access Infusion Care Company

AMVUTTRA (VUTRISIRAN) ORDERS

PATIENT INFORMATION		PRESCRIBER INFORMATION
Patient Name: _____		Prescriber Name: _____
Address: _____		NPI: _____
City, State, Zip: _____		Address: _____
Cell: _____	Email: _____	City, State, Zip: _____
Height _____ Weight _____		Phone: _____ Fax: _____
Last 4 of SSN: _____ DOB: _____		Contact Person: _____
Allergies: _____		

REFERRAL STATUS

☐ New Referral	☐ Is this the first Dose? Yes/No
☐ Dose or Frequency Change	☐ If no, date of last infusion
☐ Continuation Order	Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other

DIAGNOSIS (MUST SELECT ONE)

☐ E85.1 Neuropathic heredofamilial amyloidosis	☐ E85.82 Wild-type transthyretin-related (ATTR) amyloidosis
☐ Other diagnosis: _____	☐ E85.4 Organ-limited amyloidosis
	☐ ICD-10 CODE: _____

REQUIRED DOCUMENTATION

☐ This signed order form by the provider	☐ Cardiac PYP Scan
☐ Patient demographics AND insurance information	☐ Echocardiogram (if available)
☐ Labs and tests supporting primary diagnosis: Monoclonal Protein levels	☐ Ensure patient is taking Vitamin A supplementation

PRESCRIBING INFORMATION

Medication	Dose/Strength	Directions	Quantity
☐ Amvuttra (vutrisiran)	25 mg/0.5 mL	☐ Inject 25 mg Subcutaneous once every 3 months for 1 year.	1 PFS Refill: 4
		☐ Observe patient post injection for 30 minutes after initial injection. If no reaction noted, additional observation times are not required.	

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline as appropriate
RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration as appropriate
RN to flush and lock VAD/CVAD per company protocol
Other: _____

EMERGENCY MEDICATION

Administer the following medications as needed for infusion-related reactions per company protocol:

Adults (>40 kg): Diphenhydramine 25–50 mg PO or IV slow push (2–5 min); Acetaminophen 325–650 mg PO; Methylprednisolone 125 mg IV slow push (≥5 min); Epinephrine 0.3 mg IM/SQ, may repeat ×1; 0.9% NS 500 mL IV over 30–60 min, may repeat ×1 for hypotension.

Oxygen (AIC/AIS only): 1–6 L/min via NC or face mask; titrate to maintain SpO_2 95–100%.

Prescriber Signature X: _____ X: _____
Product Substitution Permitted: _____ Date: _____ Dispense as Written: _____ Date: _____

Print, complete, and fax completed form to: (406) 752-0443