



AMVUTTRA (VUTRISIRAN) Injection Orders

PHONE 515.225.2930 | FAX 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

Patient Name: _____ **DOB:** _____ **Phone:** _____

Patient Status: New to Therapy Continuing Therapy **Next Treatment Date:** _____

Medical Information

Diagnosis: Hereditary transthyretin-mediated amyloidosis **ICD-10 Code:** E85.1

 Other _____ **ICD-10 Code:** _____

Patient Weight: _____ lbs. (required) **Allergies:** _____

Therapy Order

Amvuttra:

25 mg subcutaneously once every 3 months x1 year

Additional Orders: _____

Lab Orders: _____ **Lab Frequency:** _____

Provider Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* 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.

Provider Name: _____ **Signature:** _____ **Date:** _____

Provider NPI: _____ **Phone:** _____ **Fax:** _____ **Contact Person:** _____

Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): _____

Service Areas

Des Moines, IA West Des Moines, IA Chicago, IL Omaha, NE Buffalo, NY Dallas, TX

Phoenix, AZ Other _____

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COMPREHENSIVE SUPPORT FOR AMVUTTRA THERAPY

Patient Information

Patient 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 medication list

Supporting clinical notes (H&P) to support primary diagnosis, including:

Baseline polyneuropathy disability (PND) score: _____

Documentation of a gene TTR mutation

Patient has been instructed to take vitamin A supplementation

Other Medical Necessity: _____

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

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