Wells Infusion Centers

AMVUTTRA ORDER FORM

PLEASE EMAIL COMPLETED FORM AND SUPPORTING DOCUMENTATION TO REFERRALS@WELLSINFUSION.COM. YOU CAN ALSO FAX IT TO 1-570-9INFUSE (1-570-946-3873)

Preferred Location: ____________________

Patient Information

Patient Name: DOB: Sex: ☐ M ☐ F

Address: Phone: Email:

Height (in): Weight (lb): Referral Status: ☐ New ☐ Updated ☐ Renewal

Infusion/ Injection Information

Primary ICD-10 Code: Primary ICD-10 Description:

Other ICD-10 Codes: Other ICD-10 Descriptions:

Amvuttra (Vutrisiran) Dosing Info:

☐ 25 mg subcutaneous every 3 months x 1 year

Other Instructions:

☐ ____________________________________
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____
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Required Documentation:

☐ Full Patient Chart
☐ Insurance Cards (Front and Back)
☐ Clinical Notes Supporting Diagnosis
☐ List of Current Medications, Conditions, and Allergies
☐ Baseline PND Score
☐ Documentation of a gene TTR mutation
☐ Patient has not had liver transplant
☐ Diagnostic testing to confirm neuropathy
☐ Patient is taking Vitamin A

Ordering Provider Information

Practice Name: Practice Phone: Practice Fax:

Practice Address: Referral Coordinator Name:

Referral Coordinator Email: Referral Coordinator Phone:

Ordering Provider: Provider NPI: Specialty:

All Injections, Infusions, and Rescue Management for Reactions will be handled in accordance with Wells Infusion's Protocols. Orders are valid for 1 year unless stated otherwise.

Provider Name ____________________ Provider Signature ____________________ Date ____________

IF YOU HAVE ANY QUESTIONS OR CONCERNS, PLEASE CALL 570-4INFUSE (570-446-3873) OR EMAIL INFO@WELLSINFUSION.COM