Atrium Health

Atrium Health Infusion Center

Referral Status:	☐ New Start ☐ Order Change ☐ Renewal
Preferred Location:	☐ Atrium Health Infusion Center Concord **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Pineville **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Southpark **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Huntersville **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Kenilworth, a facility of CMC **Fax:** 704-512-5390
	☐ Atrium Health Infusion Center Abbey Place, a facility of CMC **Fax:** 704-512-5390
	☐ Atrium Health Infusion Center Cabarrus, a facility of CMC **Fax:** 704-512-5390

Amvuttra® (vutrisiran) Injection Order (Revised 11/5/2025)

All orders with a √ will be placed.

Patient Demographics:		
Patient Name:	Date of Birth:	MRN:
Address:		
City:	State:	Zip Code:
Allergies: (please list all allergies or attach list) ☐ NKDA		

Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)	
☐ E85.1 - Neuropathic heredofamilial amyloidosis	☐ E85.4 - Organ-limited amyloidosis
☐ E85.82 - Wild-type transthyretin-related (ATTR) amyloidosis	☐ Other:

Required Documentation: (*required prior to scheduling*)	
Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:
Copy of Insurance Card (front and back)	
Most Recent Labs (*must include labs pertinent to medication ordered*)	☐ No Washout Needed
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion: Next infusion due date:
Complete Medication List - Include all tried and failed meds	If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request.
Diagnostic Studies Pertinent to Medication Ordered	☐ Yes ☐ No

Treatment Parameters:
☑ Hold Treatment and Notify Provider IF: - Temperature is GREATER THAN 100oF; - Patient complains of symptoms of acute viral or bacterial infection; - Patient is taking an antibiotic for current infection
Required Labs Prior to Treatment: (**fax labs with order**) - CMP PRIOR to treatment ☑ Hold Treatment and Notify Provider IF: - CrCL LESS THAN 30mL/min; - AST GREATER THAN ULN OR Total Bibirubin GREATER THAN 1.5 x ULN

Provider Communication:
☑ * Amvuttra (vutrisiran) leads to decreased serum vitamin A levels; * Supplement the patient with the recommended daily allowance of vitamin A; * Refer to an opthalmologist if ocular symptoms suggestive of vitamin A deficiency occur.

Nursing Communication:
☑ May use labs from PRIOR 14 days
☑ Instruct patients: * Amvuttra (vutrisiran) leads to decreased serum vitamin A levels; * Confirm the patient is taking recommended vitamin A supplementation at home.
☑ Obtain vital signs PRE-injection. Obtain vital signs PRN POST-injection.
☑ * Inject into either the abdomen, thighs, or upper arms; * If injecting into the abdomen, inject at least 5 cm away from the navel; * Avoid injecting into the areas of scar tissue or areas that are actively red, swollen, or inflamed.
☑ Monitor patient for signs of reaction for 30mins after completion of 1st injection and subsequent injections PRN if previous signs of reaction observed.

Infusion Therapy:
☑ Amvuttra (vutrisiran) 25mg SC every 12 weeks

Hypersensitivity Protocol:
☑ Initiate Atrium Health approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Infusion Center website at atriumhealth.org/infusion.

Prescriber Information:	
Provider Name:	Phone: Fax:
Practice Name:	NPI:
Address:	Office Contact:
City, State, Zip:	Office Contact Phone Number:

Physician Signature: (*Order expires 12 months from date of signature*) No Stamp Signatures Accepted	
Signature:	Date: