BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

AMVUTTRA (VUTRISIRAN) INJECTION ORDERS

FAX: 470.922.3656 | **PHONE:** 470.377.6400

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 470.922.3656

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:

☐ 25mg 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 *Biocare Infusion,* 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 Biocare Infusion selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ View our locations here:

BIOCARE INFUSION
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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: _____

Biocare Infusion 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.

Please fax all information to (470) 922-3656 or call (470) 377-6400 for assistance