Ascension Rx

Vutrisiran (Amvuttra & Biosimilars) Injection Order Form

Patient Name: _____ **Date of Birth:** _____

Patient Phone #: _____ **Date:** _____

Therapy Status: ☐ New Start ☐ Continuation ☐ Restart **Last Dose:**_____

Height (inches)	Weight (kg)	Allergies

Diagnosis

ICD-10 Code(s): _____ J Code(s): _____

Labs (Recommended to be done within 30 days of first dose)

- ☐ Labs to be reviewed or ordered by infusion center
  - ☐ Baseline
    - ☐ CMP
    - ☐ CBC with Differential
    - ☑ Serum Vitamin A level
    - ☑ Transthyretin (TTR) serum level
    - ☐ NT-proBNP baseline
    - ☐ Troponins
  - ☐ Maintenance (every _____)
    - ☐ CMP
    - ☐ CBC with Differential
    - ☑ Serum Vitamin A level
    - ☑ Transthyretin (TTR) serum level
    - ☐ NT-proBNP baseline
    - ☐ Troponins

- ☐ Labs reviewed by ordering provider, ok to proceed (Labs last done on _____)
- ☐ Other: _____

Provider Information

Vitamin A supplementation at recommended daily allowance
Refer patient to ophthalmology if ocular symptoms develop - may indicate vitamin A deficiency

Nursing Order

- ☑ Do not administer Vutrisiran with an active infection, including clinically important localized infection, or if patient is taking antibiotics for current infection.

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- [x] Live vaccines should **NOT** be given concurrently with vutrisiran
- [x] Pregnancy status: If uncertain, obtain HCG urine test for women 11 – 50 years prior to treatment.

Medication Orders

Standard Dose

- [x] Vutrisiran 25 mg/ 0.5 mL subcutaneous once every 3 months

Refills:
(Refills for one year from date of signature unless indicated)

- [ ] Zero
- [ ] For 12 months
- [ ] _____

To be completed by Infusion Center staff only:

Biosimilar substitution/Product Dispensed: _____ J-Code: _____
Rounded Dose: _____ mg

Rationale for Substitution:

- [ ] Payer-mandated substitution
- [ ] Financial stewardship
- [ ] Patient access / hardship

Pharmacy may substitute a biosimilar based on insurance coverage.
Pharmacy may adjust diluent, volume, and infusion duration in accordance with local practice standards.

Administration Instructions

Administer into the abdomen (avoiding the area within 2 inches of the navel), upper thighs, or the outer/posterior upper arm. Rotate injection sites with each dose; do not inject into skin that is tender, bruised, red, scaly, or hard.

Infusion Center Staff

Please fax infusion records or discharge summary to: Fax Number _____

Provider Information

Provider Signature: _____ Date: _____

Provider Printed Name: _____ Provider NPI: _____

Provider Address: _____ Phone: _____ Fax: _____

All orders are valid for 1 year from the ordered date unless otherwise indicated