McLeod Health

Vutrisiran (Amvuttra) Treatment Plan

Patient Name: _____ DOB: _____

Height (cm): _____ Weight (kg): _____ Allergies: _____

Patient Primary Phone Number: _____

Diagnosis (select one):

☐ E85.1 – Neuropathic heredofamilial amyloidosis ☐ E85.4 Organ-limited amyloidosis

☐ E85.82- Wild-type transthyretin-related (ATTR) amyloidosis

☐ Other: ICD 10 Code: _____ Diagnosis Description: _____

Drug Orders:

- Vutrisiran (Amvuttra) (J0225) 25 mg/0.5 mL via subcutaneous injection every 3 months

☐ Other: _____

- Order Duration: Twelve months unless otherwise specified (Other: _____)

Standing Orders:

- Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.

Physician Signature: _____ **Date:** _____

Physician Name: _____ **Phone:** _____

Previous Therapies:

- For new patient referrals, please send history and physical and most recent physician note with completed plan
- If patient has previously received Vutrisiran at another facility, please provide last date received: _____
- If patient has previously received another biologic therapy, please provide the name: _____

and the last date received: _____

Insurance Information:

Insurance Plan Name: _____

Insurance Identification Number: _____

Insurance Customer Service Contact Number: _____

Preferred Treatment Location

☐ McLeod Regional Medical Center (Florence) ☐ McLeod Health Loris ☐ McLeod Health Cheraw

☐ McLeod Health Seacoast (Little River) ☐ McLeod Health Dillon ☐ McLeod Health Clarendon (Manning)

Fax completed Treatment Plan to the McLeod Medication Access Team at 843-777-9798.
For any questions, please contact our team at medicationaccessteam@mcleodhealth.org.