



GREATER BOSTON INFUSION CENTER

17/19 Kendrick St, Wrentham, MA 02093
P 774-581-0032 | F 774-581-0033

PAGE 1

Amvuttra - Referral Checklist

Referral packet checklist

Complete this page and attach the supporting items below.

PATIENT & REFERRING PROVIDER

PATIENT NAME

DOB

DATE

REFERRING PROVIDER

NPI

DIRECT CONTACT / EXT.

OFFICE / PRACTICE

PHONE

FAX

EMAIL

URGENT CLINICAL CONTACT

REQUIRED REFERRAL PACKET

- ☐ Patient demographics and contact information
- ☐ Primary and secondary insurance information; front/back card copies
- ☐ Supporting clinical notes / office visits documenting Amvuttra treatment plan
- ☐ Current medication list and allergies
- ☐ Relevant laboratory results / imaging and baseline safety information
- ☐ Completed Amvuttra prescribing order (following page)

MEDICATION-SPECIFIC CLINICAL DOCUMENTATION

- Note should include any therapies tried/failed, and must include discussion about Amvuttra
- Medication list and allergies
- hATTR-PN or ATTR-CM diagnostic results

GBIC INTERNAL USE

REFERRAL RECEIVED

BENEFITS VERIFIED

PA STATUS / THROUGH

SCHEDULED



GREATER BOSTON INFUSION CENTER

17/19 Kendrick St, Wrentham, MA 02093

P 774-581-0032 | F 774-581-0033

PAGE 2

Prescribing Order - Amvuttra (vutrisiran)

☐ New Start

☐ Maintenance

DATE OF LAST DOSE / INFUSION

ORDER DETAILS

DATE OF ORDER

PATIENT NAME

DOB

M/F

DIAGNOSIS / ICD-10

☐ NKDA

PATIENT WEIGHT

ALLERGIES

PREMEDICATIONS

☐ Acetaminophen 1000mg PO

☐ Diphenhydramine 25mg PO

☐ Loratadine 10mg or Cetirizine 10mg PO

☐ Other

MEDICATION ORDER

☐ Amvuttra 25mg/0.5ml SQ every 3 months

☐ Other

ADMINISTRATION & MONITORING

✓ Administer Amvuttra as a subcutaneous injection in the thigh, abdomen, or upper arm

✓ In case of reaction, follow GBIC infusion reaction protocol. Notify physician.

✓ Signature Date

PROVIDER AUTHORIZATION

ORDERING PROVIDER NAME

NPI

DATE

SIGNATURE

Handwritten or compliant electronic signature

OFFICE PHONE / EXT.