ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:	Fax all infusions to: 833-380-8800 Please mark the appropriate Infusion center	▫ Allenmore Infusion Center ▫ Auburn Infusion Center ▫ Gig Harbor Infusion Center ▫ Puyallup Infusion Center	▫ DHEC Infusion Center ▫ North Spokane Infusion Center ▫ North Star Lodge Infusion Center

ORDERS WITH CHECK BOXES — When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Vutrisiran (Amvuttra)

Patient Name: _____Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ □ May leave message

Diagnosis: □ Polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults

ICD -10 Code: □_____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs and documentation ***If required documentation not received with order, scheduling of treatment will be delayed until complete information is available***

Baseline labs required:
- None

Maintenance labs required:
□ None

Treatment Regimen:
▫ Vutrisiran (Amvuttra) 25mg SUBQ every 3 months

NOTE: Supplementation at the recommended daily allowance of vitamin A is advised for patients taking Vutrisiran. Patients should be referred to an ophthalmologist if they develop ocular symptoms suggestive of vitamin A deficiency.

☑ **Vital Signs:** Check vital signs prior to and at completion of infusion.
Contact provider if systolic BP >180; diastolic BP >100; systolic BP <90; HR >110; temp >38C (100.4F)

If hypersensitivity develops (fever, chills, hypotension, rigors, itching, rash, etc.):
- Consult MultiCare hypersensitivity guideline for treatment management
- Notify provider of reaction, assessment and need for further orders

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: □ Yes □ No (if yes, please send DOCUMENTATION of consent with order)

_____ _____ _____ _____

Provider Signature | Print Name | Date | Time

Orders expire in 12 months**

Patient Identification - Always Attach Patient Label Name: MRN: CSN: Age/Sex and Gender:	**Pre-Printed Order** POLYNEUROPATHY OF HEREDITARY TRANSTHYRETIN-MEDIATED AMYLOIDOSIS **Insert MultiCare logo** — **Insert Bar Code and Insert Order number**