Email: intake@sageinfusion.com I Online: www.sageinfusion.com
Serving Central and Southwest Florida

AMVUTTRA Injection Order

Patient Name: DOB: ☐ Male ☐ Female

Diagnosis (please specify if not on the list below)

☐ (E85.1)Polyneuropathy of haTTR amyloidosis ☐ (E85.82)Cardiomyopathy of wtATTR amyloidosis ☐ (E85.4)Cardiomyopathy of hATTR amyloidosis

☐ NKDA Allergies:

☐ New Start Therapy ☐ Continuation of Therapy Date of last dose (if applicable):

Ordering Provider:

Provider NPI: Phone: Fax:

Practice Address: City: State: Zip Code:

PRE-MEDICATION

☐ Acetaminophen1000mg PO
☐ Diphenhydramine 25mg PO
☐ Ceterizine 10mg PO
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP

REQUIRED LABS

☑ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (please attach)

AMVUTTRA ORDERS

DOSING:

☐ 25mg SQ injection every 3 months

REFILLS:

☐ _____

(if not indicated prescription will expire one year from date signed)

☑ **Sage Infusion Standing Orders:**

Provide treatment under Sage Infusion's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

_____
Provider Name

_____ _____
Provider Signature Date