Sarah Bush Lincoln

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Neuropathic heredofamilial amyloidosis ICD 10 Code: E85.1

☐ Other: _____ ICD 10 Code: _____

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ This signed order form by the provider

☐ Patient demographics AND insurance information

*Patient may be required to submit a pregnancy test prior to treatment

☐ Clinical/Progress notes (must be within 1 year)

☐ Labs and Tests supporting primary diagnosis

☐ Is the patient on a supplement with the recommended daily allowance of vitamin A? ☐ Yes ☐ No

List Tried & Failed Therapies, including duration of treatment:

1)

2)

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt (in kg): BMI: **Patient weight required for weight-based orders.

Dosing ☐ J0225 Amvuttra (vutrisiran) 25mg SubQ every 3 months

Duration ☐ **X 6 months** ☐ **X 1 year** ☐ _____ **doses**

ADDITIONAL ORDERS / INFORMATION

PRESCRIBER INFORMATION

Prescriber name :		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr.
Suite 204
Mattoon, IL 61938
Ph. 217-258-4150
Fax 217-348-2579

☐ EFFINGHAM
901 Medical Park Dr.
Suite 201
Effingham, IL 62401
Ph. 217-342-7500
Fax 217-342-7499

INFUSION ORDERS - Amvuttra (VUTRISIRAN)

Clinics Scan to: Physician Orders