

1311 W Sam Houston Pkwy N Ste 100, Houston, TX 77043
T (832) 500-3727 **F** (832) 500-8629 **E** specialty@hqrx.com

LAST TREATMENT DATE: _____ NEXT DUE DATE: _____

Please fax completed form along with copy of patient's insurance cards and any labs to **(832) 500-8629**

Patient Name _____ Patient Address _____ City _____ State _____ Zip _____ Day Phone _____ Work Phone # _____ Cell Phone _____ Date of Birth _____ <input type="checkbox"/> Male <input type="checkbox"/> Female E-mail _____	Prescriber's Name _____ DEA # _____ NPI # _____ Practice Name _____ Office Contact _____ Address _____ Suite # _____ City _____ State _____ Zip _____ Phone _____ Fax _____
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DIAGNOSIS

Patient: Wt. _____ Ht. _____ Allergies: Latex Other, specify _____
 Diagnosis: _____ (ICD-10 Code: _____)

PRESCRIPTION

MEDICATION	INFUSION ORDERS	REFILLS
Amvuttra (vutrisiran)	<input type="checkbox"/> 25mg SubQ once every 3 months	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____
Other orders _____		
Lab orders _____ Lab Frequency _____		

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- Supporting documentation for tried and failed Vyndamax (tafamidis) therapy or specific reason why it is not appropriate for patient to use
- Include **signed** and **completed** order (MD/prescriber to complete page 1)
- Include patient demographic information and insurance information
- Include patient's current medication list
- Supporting clinical notes (H&P) to support primary diagnosis - Including
 - Documentation of gene TTR mutation
 - Please indicate New York Heart Association Class (NYHA):
 I II III IV
- For polyneuropathy diagnosis (please answer):
 - Baseline polyneuropathy disability (PND) score: _____
 - Baseline familial amyloid polyneuropathy (FAP) stage: _____
- Patient has been instructed to take Vitamin A supplementation
- Other medical necessity: _____

I authorize HealthQuest Infusion & Specialty and its representatives to initiate and execute any insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above as well as selecting the preferred site of care for the patient. I understand that I can revoke this designation at any time by providing written notice to HealthQuest Infusion & Specialty.

PRESCRIBER'S SIGNATURE (Signature required. No stamps.) _____ **DATE** _____

IMPORTANT NOTICE: This facsimile is intended to be delivered to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee.