

AMVUTTRA Injection Order

Patient Name: _____ DOB: _____ Male Female

Diagnosis (please provide ICD10 code): _____

Other: _____

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

- Acetaminophen 1000mg PO Solu-Medrol 125mg IVP
- Diphenhydramine 25mg PO Solu-Cortef 100mg IVP
- Ceterizine 10mg PO 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)

Infuse One Standing Orders:

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

Provider Name

Provider Signature

Date