Email: intake@infuseone.com | Phone: 1-800-581-0645 |
Please refer to website www.infuseone.com for location specific fax numbers

INFUSE ONE

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

☐ Acetaminophen1000mg 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