Cumberland Vital Care
Fax Referral To:
(931) 456-4857
Direct Phone: (931) 456-0680

CUMBERLAND VITAL CARE
PHARMACEUTICAL COMPOUNDING & INFUSION SERVICES

AMVUTTRA ORDER FORM

Date:

Patient Name:

Date of Birth:

ICD-10 Code: _____

Allergies: _____

Weight: _____lbs OR _____kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

Provider Information

Ordering Provider: _____
Provider NPI: _____
Provider Phone: _____
Provider Fax: _____
Provider Address: _____

MEDICATION ORDER

☐ Amvuttra

✓ Amvuttra 25mg to be given subcutaneously every three months per protocol.

✓ Prescriber has instructed patient to take vitamin A supplementation.

Refills x one year from date of signature unless indicated below.

☐ _____ Refills

PRE-MEDICATIONS

Oral
☐ Acetaminophen: ___325mg ___500mg __650mg
☐ Loratadine: 10 mg
☐ Cetirizine: 10mg
☐ Diphenhydramine: ___25mg ___50mg
☐ Famotidine: ___20mg ___40mg
☐ Ibuprofen: ___200mg ___400mg ___600mg
☐ Ondansetron: ___4mg ___8mg
☐ Other_____

IV
☐ Dexamethasone: ___4mg ___8mg
☐ Diphenhydramine: ___25mg __50mg
☐ Famotidine: ___20mg ___40mg
☐ Methylprednisolone 125mg
☐ Hydrocortisone 100mg
☐ Ondansetron: ___4mg ___8mg
☐ Other_____

LAB ORDERS (Please indicate any labs to be drawn and frequency)

Surveillance lab ordering, and monitoring is the responsibility of the prescriber

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Ofice Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that above therapy is medically necessary Prescriber's Signature (SIGN BELOW)

Dispense as Written:

_____ _____
Prescriber Name Date

Substitution Allowed:

_____ _____
Prescriber Name Date

V 7.14.22