# Givlaari Order Form
## (givosiran)

**FAX TO: 972.499.9210**

## PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

**Patient Preferred Location:** _____

## <ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

**ICD 10 Code**

☐ E80.20 Unspecified porphyria

☐ E80.21 Acute intermittent (hepatic) porphyria

☐ E80.29 Other porphyria

***REQUIRED*: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

***LAB RESULTS:* Include baseline CMP or AST/ALT and homocysteine level.**

## PRESCRIPTION

**GIVLAARI (givosiran)**

**Loading Dose**

☐ Administer 1.25 mg/kg by subcutaneous injection once for one year

☐ Administer 2.5mg/kg by subcutaneous injection once for one year

**Referring provider to obtain labs and monitor hepatic function, rental function, and homocysteine as clinically indicated during treatment with Givlaari**

**Post Treatment Observations:** The patient is observed for 30 minutes following the first administration.

**Adverse Events:** In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

**Comments:**

_____

_____

_____

## PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____