medix infusion

Givlaari Order Form
(givosiran)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____

DOB: _____ Phone: _____ Sex: ☐ M ☐ F

DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (Required)

- ☐ E80.20 Unspecified porphyria
- ☐ E80.21 Acute Intermittent (hepatic) porphyria
- ☐ E80.29 Other porphyria

Weight: _____ ☐ lb ☐ kg Height: _____

Patient Status:

- ☐ New to therapy
- ☐ Continuing therapy (date of last dose _____)

Allergies: _____

PRESCRIPTION

GIVLAARI (givosiran)

- ☐ Administer 1.25 mg/kg by subcutaneous injection once monthly for one year
- ☐ Administer 2.5 mg/kg by subcutaneous injection once monthly for one year (Recommended starting dose)

Lab Orders:

- ☐ MST/ALT monthly for first 6 months of therapy, then every _____ months thereafter
- ☐ Renal function every _____ months
- ☐ Homocysteine level every _____ months
- ☐ Other lab orders: _____ Frequency: _____

Is the patient on any other disease modifying therapy? ☐ **Yes** ☐ **No**

Is yes, please note therapy and last dose: _____

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

Other Orders: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- Signed and completed order
- Patient's demographic and insurance information
- Patient's medication list
- Supporting clinical notes that include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

Supporting labs/diagnostics:
Baseline CMP or AST/ALT and homocysteine level

Medix Infusion will collect all necessary labs if not included in referral documents

PRESCRIBER INFORMATION

Prescriber Name: _____

Signature: _____

NPI #: _____ Date: _____

Supervising Physician (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____