

GIVLAARI

Please include the following to expedite the order:

Patient Demographics, Insurance Information, Labs

PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Name: _____ DOB: _____ Gender: ☐ M ☐ F ☐ Other _____
Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

PRESCRIBER

Name: _____ DEA: _____ NPI: _____ State License: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

CLINICAL

Diagnosis: ☐ E80.20 (Unspecified Porphyria) ☐ E80.21 (Acute Intermittent Hepatic Porphyria)
☐ E80.29 (Other Porphyria) ☐ Other: _____

Allergies: _____ Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in

Homeocysteine tested: ☐ Yes ☐ No

CBC Completed: ☐ Yes ☐ No CMP/LFTs Completed: ☐ Yes ☐ No

TREATMENT

GIVLAARI (givosiran)

Route: Subcutaneous Injection

Dose: ☐ 1.25mg/kg ☐ 2.5mg/kg

Frequency:

☐ Once a month

Quantity: _____ Refills: _____

Premedication Protocol:

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV
☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO
☐ Other: _____

Sig: _____

☒ Center will use anaphylactic and hypersensitivity protocol established by Restore Health

Special Instructions: _____

Provider Signature: _____

Date: _____

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