RESTORE HEALTH
INFUSION AND WELLNESS

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: _____