RESTORE HEALTH
INFUSION AND WELLNESS

GIVLAARI

Please include the following to expedite the order:
Patient Demographics, Insurance Information, Labs

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ **DOB**: _____ **Gender**: ☐M ☐F ☐Other _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

PRESCRIBER INFORMATION

Prescriber Name: _____ **DEA:** _____ **NPI:** _____ **State License:** _____

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

Phone: _____ **Fax:** _____

CLINICAL INFORMATION

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 INFORMATION

GIVLAARI (givosiran)

Route: Subcutaneous Injection

Dose: ☐1.25mg/kg ☐2.5mg/kg

Frequency:

☐ Once a month

Premedication Protocol:

☐ Diphenhydramine: ☐25mg ☐50mg ☐PO ☐IV

☐ Acetaminophen: ☐325mg ☐500mg ☐650mg PO

☐ Other: _____

Sig: _____

Special Instructions: _____

Quantity: _____ **Refills:** _____

Provider Name: _____ Provider Signature: _____ Date: _____

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