Givlaari
(givosiran)

Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:
Patient Demographics; Insurance Information; All Clinical Documentation Supporting the Diagnosis, Including Any Previous or Current Therapies, Pertinent Labs, or Diagnostic Testing; Recent Labs including CMP and Blood Homocysteine Levels

PATIENT INFORMATION

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

Patient Name: Patient Phone: DOB:

ICD-10 code (required): ☐ E80.20 ☐ E80.21 ☐ E80.29 ICD Description:

Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

NURSING

- ☑ Center will use Hypersensitivity protocol established by Infusion for Health and PI
- ☑ Liver Function Tests
- ☑ Creatinine and eGFR
- ☑ Blood Homocysteine Levels

PRE-MEDICATION ORDERS

Pre-Medications not usually indicated.

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

Dose: _____ Route: _____

SPECIAL INSTRUCTIONS:

LABORATORY ORDERS

- ☐ CBC ☐ at each dose ☐ every _____
- ☐ CMP ☐ at each dose ☐ every _____
- ☐ Homocysteine ☐ at each dose ☐ every _____
- ☐ Other _____ Frequency: _____

☐ Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

THERAPY ADMINISTRATION

- ☑ Givlaari Subcutaneous Injection
- ☐ 2.5 mg/kg once monthly
- ☐ 1.25 mg/kg once monthly
- ☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
  (if not indicated, order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.

Provider Name (Print) Provider Signature Date

☐ ***Please check this box if you DO NOT authorize Infusion for Health to complete a Peer-to-Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.***