Givosiran (Givlaari)





PATIENT INFORMATION	Referral Sta	tus: □ New R	eferral 🔲 Updated (Order 🗆 Order Renewal
Patient Name:		DOB:	Patient F	
Patient Address:			Patient Email:	
Allergies:		□ NKDA	Weight (lbs/kg):	Height (in/cm):
Sex: ☐ M / ☐ F Date of Last Infusion:	Next Due		Preferred Location	
Date of Last Illiusion.	Next Due	Date.	Treferred Location	
DIAGNOSIS (Please provide ICD-10 code in spe	ace provided)			
Acute Hepatic Porphyria:				
Other: Descri	ption:			
THERAPY ADMINISTRATION (Select one) □ Administer Givlaari 2.5mg/kg x kg = _ sub-q every month □ Administer Givlaari mg sub-q every mone ☑ Monitor for injection site reaction. Monitor patient after first injection. DOSING INFORMATION Dose reduction to 1.25mg/kg may be needed if patient significant change in transaminase levels (AST/ALT). ADDITIONAL ORDERS	nth ent for 15mins ient has a	☐ Other: LABORATO ☐ Other: NURSING ☑ Hold infus • AST • Dec	cion and notify provider or ALT greater than 3 to creasing renal function ursing care per Nursing wity Reaction Managements observation	for: imes normal level Procedure, including
PROVIDER INFORMATION Preferred Contact Name:		Prei	ferred Contact Email:	
Ordering Provider:		Provider NPI:		
Referring Practice Name:		Phone: Fax:		-
Practice Address:		City:	State:	Zip Code:
REQUIRED DOCUMENTATION CHECKLIST	Γ (Additional doc	cumentation rea	uired for processina a	nd insurance approval)
Required Documentation: Patient demos, copy of treatment failures or contraindications, LFTs prio Required Labs: Blood homocysteine levels, Rena	of front and back or to starting treat	of primary and street	secondary insurance, 2	most recent OVN including
Provider Name (print)	 Provider Signature			