Givosiran (Givlaari)

Provider Order Form rev. 01/02/2024

PATIENT INFORMATION

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

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Acute Hepatic Porphyria:

Other: Description:

THERAPY ADMINISTRATION *(Select one)*

☐ Administer Givlaari 2.5mg/kg x _____ kg = _____ mg sub-q every month

☐ Administer Givlaari _____ mg sub-q every month

☑ Monitor for injection site reaction. Monitor patient for 15mins after first injection.

DOSING INFORMATION

Dose reduction to 1.25mg/kg may be needed if patient has a significant change in transaminase levels (AST/ALT).

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- AST or ALT greater than 3 times normal level
- Decreasing renal function

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, LFTs prior to starting treatment and every month for the first 6 months of treatment.

Required Labs: Blood homocysteine levels, Renal function, hepatic function

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.