EXPECARE FAMILY CARE URGENT CARE OF TEXAS

Givlaari Order Form
(givosiran)

FAX TO: 817-472-7213

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code

☐ E80.20 Unspecified porphyria

☐ E80.21 Acute intermittent (hepatic) porphyria

☐ E80.29 Other porphyria

REQUIRED: **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

LAB RESULTS: **Include baseline CMP or AST/ALT and homocysteine level.**

PRESCRIPTION

GIVLAARI (givosiran)

Loading Dose

☐ Administer 1.25 mg/kg by subcutaneous injection once for one year

☐ Administer 2.5mg/kg by subcutaneous injection once for one year

Referring provider to obtain labs and monitor hepatic function, rental function, and homocysteine as clinically indicated during treatment with Givlaari

Is the patient on any other disease modifying therapy? ☐ **Yes** ☐ **No**
If yes, please note therapy and last dose: _____

Post Treatment Observations: The patient is observed for 30 minutes following the first administration.

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

Comments:

_____

_____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

Contact Name: _____ Phone: _____ Fax: _____ Email: _____