



GIVLAARI™ (givosiran) ORDER FORM

(* - Required Fields)

STAT REQUEST

(*REASON MUST BE PROVIDED BELOW)

<input type="checkbox"/> New Referral	<input type="checkbox"/> Order Renewal	<input type="checkbox"/> Medication/Order Change
<input type="checkbox"/> Benefits Verification Only	<input type="checkbox"/> Discontinuation Order	

Locations:

-----Oklahoma-----
 Tulsa

PATIENT INFORMATION			
NAME*:		DOB*:	SEX: M F
ADDRESS:		PHONE:	
WEIGHT:	LBS KG	HEIGHT:	EMAIL:
ALLERGIES:			

PHYSICIAN INFORMATION			
PHYSICIAN NAME*:		PRACTICE NAME:	
ADDRESS:		OFFICE CONTACT*:	
PHONE:	FAX:	EMAIL (FOR UPDATES):	

GIVLAARI ORDER*: <i>(SELECT ONE OF THE FOLLOWING)</i>	ICD-10*: _____
<input type="checkbox"/> Dose: 2.5 mg/kg once monthly by subcutaneous injection	
Physician Signature* _____	Date* (Order is Valid for One Year) _____ <i>Infusion will be administered per policy and protocols</i>

REQUIRED DIAGNOSIS:

E80.20 Unspecified porphyria

E80.21 Acute intermittent (hepatic) porphyria

E80.29 Other porphyria

***STAT REASON:**
(STAT request will be assessed per MPP policy and protocol)

REQUIRED DOCUMENTATION CHECKLIST:

Patient Demographics

Insurance Card/Information

Clinical/Progress Notes supporting DX

Current Medication List and H&P

Liver Function Test (w/in 1 year)

Last Infusion/Injection Date: _____

STANDING LAB ORDERS: CMP CBC

Labs to be drawn by Infusion Center Frequency _____

NOTES/ADDITIONAL COMMENTS: