

GIVLAARI® (givosiran)

Patient Information

Full Name: _____ Weight: _____ lbs kg Height: _____
DOB: _____ Allergies: NKDA _____
Phone Number: _____
Patient Status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

Required Documentation

- | | | |
|--|--|---|
| <input type="checkbox"/> Patient Demographics and Insurance Card | <input type="checkbox"/> Medication List | <input type="checkbox"/> Liver and renal function tests |
| <input type="checkbox"/> Clinical/Progress Notes Supporting Dx | <input type="checkbox"/> Recent labs | <input type="checkbox"/> Blood homocysteine level |

Primary Diagnosis

 ICD-10 Code (required): _____

Acute hepatic porphyria (AHP)

Other: _____

Therapy Administration

Givlaari 2.5 mg/kg subQ injection once monthly

Other: _____

Refills:

x 1 year

Other: _____

Administer acute infusion and anaphylaxis medications per violet health protocol (see violetinfusions.com/protocol for policy)

RN to administer ordered therapy per manufacturer guidelines.

Other: Please fax alternative reaction orders or nursing administration orders if checking this box

 Order valid for one year unless otherwise stated

Special Orders

Provider Information

Provider Name: _____ Office Contact Person: _____
Referring Practice Name: _____ Phone Number: _____
Referring Practice Address: _____ Fax Number: _____
City, State, Zip: _____ Email: _____
Provider NPI: _____
Provider Signature: _____ Date: _____