

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

## Givlaari® (givosiran) Standard Plan of Treatment

### PATIENT DEMOGRAPHICS:

Date of Referral:	Patient's Phone:
Patient Name:	Address:
Date of Birth:	City, State, Zip:
Height in inches:	Weight: LB or KG
Gender:	Allergies:
<input type="checkbox"/> See list	<input type="checkbox"/> NDKA

### DIAGNOSIS: (PLEASE COMPLETE 2<sup>ND</sup> AND 3<sup>RD</sup> DIGITS TO COMPLETE ICD 10 FOR BILLING)

<input type="checkbox"/> E80.20 - Unspecified porphyria
<input type="checkbox"/> E80.21 - Acute intermittent (hepatic) porphyria
<input type="checkbox"/> E80.29 - Other porphyria
<input type="checkbox"/> - Other:

### REQUESTED DOCUMENTATION:

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INJECTION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INJECTION DATE:
4	Tried and failed therapies	FROM PREVIOUS	<b>IF ORDER CHANGE:</b>
5	Baseline serum creatinine	THERAPY:	
6	Baseline glomerular filtration rate		
7	Baseline liver function tests		<b>Continue current order until insurance approved</b>
8	Urine porphobilinogen (PBG)		

### MEDICATION ORDERS:

NOTE: We may require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for this treatment through Medicare and/or other insurance plans.

### DOSE/FREQUENCY:

Givlaari® 1.25mg/kg once monthly as a subcutaneous injection(s) in the abdomen, upper arm(s), or thigh(s)

Givlaari® 2.5mg/kg once monthly as a subcutaneous injection(s) in the abdomen, upper arm(s), or thigh(s)

**Referring physician will be responsible for obtaining and monitoring labs.**

### SPECIAL ORDERS:

Refills x 12 months unless noted otherwise here:

### LINE USE/CARE ORDERS:

Start PIV/Access CVC

Flush device per facility standard flushing procedure

### ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion/AccuRX standing adverse reaction orders, which can be found at our website or scan here.



### PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

### PRESCRIBER SIGNATURE: (No stamp signatures)

DATE

Dispense as written/Brand medically necessary	Substitution permitted	



## Checklist for referrals to AccuRX Infusion:

Fax referral to 1.866.990.3192

- Patient demographics – address, phone number, SS#, etc.**
- Insurance Information – copy of the card(s) if possible**
- Plan of Treatment/Orders**
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- Any lab results or other diagnostic procedures to support the diagnosis**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with the patient and refer them to any available co-pay assistance as required. AccuRX Infusion Call Center 888.410.0317. Thank you for the referral.

[www.AccuRXInfusion.com](http://www.AccuRXInfusion.com)