Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:
☐ New referral	☐ Order change	☐ 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:	☐ See list ☐ NDKA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

- ☐ E80.20 - Unspecified porphyria
- ☐ E80.21 - Acute intermittent (hepatic) porphyria
- ☐ E80.29 - Other porphyria
- ☐ _____ - Other:

REQUESTED DOCUMENTATION:

1	Insurance information	
2	Most recent History & Physical	
3	Full medication list	
4	Tried and failed therapies	
5	Baseline serum creatinine	
6	Baseline glomerular filtration rate	
7	Baseline liver function tests	
8	Urine porphobilinogen (PBG)	

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO:

PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF YES:

LAST INJECTION DATE:

NEXT INJECTION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

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 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	