

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

Rev 4.28.25

Givlaari® (givosiran) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Patient Name:	
Patient's Phone:	Address:
Date of Birth:	City, State, Zip:
Height in inches:	Weight: LB or KG Gender: Allergies: See list NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD 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:

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

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

NURSING ORDERS:

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Start PIV/Access CVC

Flush device per facility standard flushing procedure

Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated.

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

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 Palmetto Infusion: Fax referral to 1.866.872.8920

- 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 patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.palmettoinfusion.com