

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: _____ Acute Hepatic Porphyria ICD-10 Code: E80.21
 _____ Other: _____ ICD-10 Code: _____
 Allergies: _____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes, labs, test supporting primary diagnosis
- Recent lab values necessitating dose adjustment
- Medication List

Patient	
Weight: _____	lbs.
Height: _____	in.

4. Infusion Center – Lab Orders (Check for Infusion Center to Manage):

LFTs and Serum Creatinine monthly

GIVLAARI® (givosiran)

J Code: J3490

5. Drug Order:

Recommended Dose if Reduction is Required:

Administer 1.25 mg/kg (_____ mg) subcutaneously each month _____ # Refills (Recommend 11 Refills)

Pre-Medication Orders: _____

No pre-medications are recommended based on manufacturer guidelines.

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

6. Physician Signature: _____ / _____ Date: _____

Dispense as written

Substitution permitted

Printed Physician's Name: _____ Contact Phone #: _____

FAX ALL INFORMATION CENTRAL FAX 803.999.1754	INFUSION CENTER LOCATIONS BERKELEY CHARLESTON COLUMBIA GREENVILLE CENTRAL INTAKE PHONE 803.999.1760
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