



## **INFUSION & MEDICAL CENTER**

1.	Patient Name D	OB	Patient Phone/Cell #
	Patient demographic and insurance informa	tion to be faxed with I	nfusion Order Form
2.	Medical Information (Please select primary diagnosis and complete ICD10 Code):		
	Primary Diagnosis: Acute Hepatic Porphyria Other:		ICD-10 Code: E80.21 ICD-10 Code:
	Allergies:		
3.	Clinical Information – Please fax with Infusion Order Form:		
	<ul> <li>Clinical MD Notes, labs, test supporting primary diagr</li> <li>Medication List</li> </ul>	nosis	Patient Weight: lbs.
	Infusion Center – Lab Orders (Check for Infusion Ce	enter to Manage):	Height: in.
	LFTs and Serum Creatinine at baseline and then monthly		
	GIVLAARI® (g	ivosiran)	J Code: J3490
	Drug Order:		
	Recommended Dose: Administer 2.5 mg/kg ( mg) subcutaneously each i	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 so to serve as my prior authorization agent with		
6.	Physician Signature:/ _ Dispense as written	Substitution permitt	Date:
	Printed Physician's Name:Contact Phone #:		

FAX ALL INFORMATION
CENTRAL FAX 803.999.1754
ALTERNATE FAX 803.999.1887

INFUSION CENTER LOCATIONS

COLUMBIA CHARLESTON GREENVILLE
CENTRAL INTAKE PHONE 800.767.6337