INTRAMED Plus
infusion services

GIVLAARI®
(Dose Adjustment)

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** ALTERNATE FAX 803.999.1887	<u>INFUSION CENTER LOCATIONS</u> COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 800.767.6337

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