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	INFUSION CENTER LOCATIONS
CENTRAL FAX **803.999.1754**	**COLUMBIA CHARLESTON GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1760**

JUN 2020