

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
 • Medication List

Patient Weight: _____ lbs. Height: _____ in.

4. Infusion Center – Lab Orders (Check for Infusion Center to Manage):
 LFTs and Serum Creatinine at baseline and then monthly

GIVLAARI® (givosiran) J Code: J3490

5. Drug Order:
Recommended Dose:
 Administer 2.5 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 COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 803.999.1760
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