

**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

<b>Patient</b> <b>Weight:</b> _____ lbs. <b>Height:</b> _____ in.
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**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 #: \_\_\_\_\_

<b>FAX ALL INFORMATION</b> <b>CENTRAL FAX 803.999.1754</b> <b>ALTERNATE FAX 803.999.1887</b>	<b>INFUSION CENTER LOCATIONS</b> <b>COLUMBIA CHARLESTON GREENVILLE</b> <b>CENTRAL INTAKE PHONE 803.999.1960</b>
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