# GIVLAARI®Infusion Form

**Fax Referral To: 877-438-9380**

CONTINUUMRX Specialty Infusion Services

| Birmingham,AL | Huntsville, AL | Knoxville, TN | Nashville, TN | Chantilly, VA |
|---|---|---|---|---|
| F: 205-271-9971 | F: 256-417-6408 | F: 865-934-0249 | F: 615-645-4791 | F: 703-935-2061 |

## PREVIOUS ADMINISTRATION

**Please provide the following information:** Last Infusion Date: _____ Next Infusion Date: _____

## Patient Information

Patient Name: _____ DOB: _____ Sex: ◯ M ◯ F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: Y ◯ N ◯ ICD-10 Code: _____

Emergency Contact: _____ Phone Number: _____

***Primary Diagnosis:*** _____ Acute Hepatic Porphyria

_____ Other: _____

## *Infusion Center – Lab Orders (Check for Infusion Center to Manage):*

☐ **LFTs and Serum Creatinine at baseline and then monthly**

**Please attach the following: 1. Clinical MD Notes, labs, test supporting primary diagnosis 2. Recent lab results 3. Copy of the patient's Insurance Card 4. Medications List**

## Physician Information

| | | | |
|---|---|---|---|
| Prescribing Physician: | | Practice Name: | |
| Practice Phone: | | Practice Fax: | |
| Email: | | Office Contact: | |
| Co-managing Physician: | | Phone/Email: | |

## Medication Order

***Medication:*** **GIVLAARI® (givosiran)**

☐ ***Administer 2.5 mg/kg (_____ mg) subcutaneously each month***

☐ ***Other:*** _____

***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 below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)**

By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____

Physician's NPI# Physician's Address

_____ _____

Prescriber's Signature Date