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GIVLAARI

(Givosiran)

PATIENT DEMOGRAPHICS

Patient Name:

Date of Birth: _____ M: F: Address: _____

Phone: _____ City, State, Zip: _____

Email: _____

Allergies:

PRIMARY DIAGNOSIS

ICD-10 Code:

DOCUMENTATION (PLEASE ATTACH)

Clinical / Progress Notes, Labs, Tests supporting primary diagnosis

- Liver function test prior to starting treatment and every month for the first 6 months of treatment
- Blood homocysteine levels
- Renal function panel

Clearwell Infusion Centers will draw maintenance labs unless otherwise directed by Referring Provider

PRE-MEDICATION

<input type="checkbox"/> Acetaminophen 1000mg PO	<input type="checkbox"/> Solu-Medrol 125mg IVP
<input type="checkbox"/> Diphenhydramine 25mg PO	<input type="checkbox"/> Solu-Cortef 100mg IVP
<input type="checkbox"/> Cetirizine 10mg PO	<input type="checkbox"/> Diphenhydramine 25mg IVP
<input type="checkbox"/> Loratadine 10mg PO	<input type="checkbox"/> Other: _____

PRIMARY MEDICATION ORDER

Dosage and Frequency

GIVLAARI (Givosiran) 2.5mg/kg subcutaneous injection monthly

Patient Weight:

_____ lbs

_____ kg

NOTES

ORDERING PROVIDER

Provider Name: _____ NPI: _____
Practice Name: _____ Phone: _____
Office Contact: _____ Fax: _____
Practice Address: _____
City, State, Zip: _____

Provider Signature: _____

Date: _____