



Phone: (305)306-7147
Fax: (305)402-9559
Email: intake@clearwellinfusion.com

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"/> Ceterizine 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: _____