

Givlaari (givosiran) Injection Order Form

 405-442-7577  405-442-7223

 orders@premierinfusioncenter.com

Patient Information

- **Full Name:** _____
- **Date of Birth:** ____ / ____ / ____
- **Phone:** _____ **Email:** _____
- **Address:** _____
- **Weight:** _____ lb/kg
- **Allergies:** ☐ NKDA ☐ _____
- **Treatment Status:** ☐ New ☐ Continued **Last Treatment Date:** ____ / ____ / ____

◆ **Diagnosis (ICD-10 Selection)**

- ☐ E80.21 – Acute intermittent (hepatic) porphyria
- ☐ E80.20 – Unspecified porphyria
- ☐ E80.29 – Other porphyria
- ☐ Other: _____ **ICD-10 Code:** _____

◆ **Injection Order**

- ☐ 2.5 mg/kg subcutaneous injection once monthly
- ☐ Dose reduction to 1.25 mg/kg if AST/ALT elevation
- ☐ Observation: ☐ 15 minutes ☐ 30 minutes post-injection
- ☐ Refills: ☐ None ☐ 12 months ☐ Other: _____

◆ **Line Use & Access**

- ☐ Start PIV ☐ Access CVC ☐ Use PICC Line ☐ Flush per standard injection protocol

◆ **Adverse Reaction & Anaphylaxis Orders**

- ☐ Premier Infusion Center Protocol (premierinfusioncenter.com)
- ☐ Other – please fax preferred reaction orders to 405-442-7223

◆ **Premedication (Optional)**

- ☐ Acetaminophen: ☐ 650 mg ☐ PO
☐ Diphenhydramine: ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV
☐ Cetirizine: ☐ 10 mg ☐ PO
☐ Methylprednisolone: ☐ 125 mg ☐ IV
☐ Other: _____ **Dose:** _____ **Route:** _____

◆ **Laboratory Monitoring**

- ☐ CBC ☐ CMP ☐ AST/ALT ☐ Renal Function
☐ Blood homocysteine levels
☐ Other: _____
Frequency: ☐ Prior to first dose ☐ Monthly ☐ Other: _____
☐ Physician office will order labs only

◆ **Clinical Documentation Checklist**

- ☐ Recent progress notes ☐ Last H&P ☐ Lab results ☐ Medication list

◆ **Ordering Provider & Demographics**

- **Name:** _____
- **NPI:** _____ **License #:** _____
- **Contact:** _____ **Phone:** _____ **Fax:** _____
- **Email:** _____
- **Signature:** _____ **Date:** ____ / ____ / ____