Givosiran (Givlaari)

Provider Order Form *rev. 11/06/26*

arbor infusion

PATIENT INFORMATION

Referral Status: ☐New Referral ☐Updated Order ☐Order Renewal

Patient Name: DOB: Mobile Phone Number:

Weight (lbs/kg): ☐NKDA Allergies:

Therapy Status: ☐New to Therapy ☐Continuing Therapy Last Treatment Date: Next Due Date:

REQUIRED SUPPORTING DOCUMENTATION *(Please include the following with the order to support processing & insurance approval)*

• Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)

• Liver function tests prior to starting treatment (within 6 months of referral)

DIAGNOSIS ICD-10 CODE *(Provider must specify)*

☐E80.21 Adults with acute hepatic porphyria (AHP)

☐Other:

PRIMARY MEDICATION ORDER

Givosiran (Givlaari) 2.5mg/kg once monthly, subcutaneous injection

☐Patient is required to stay for 30-minute observation post procedure

• Refill for 12 months unless otherwise noted: _____

SPECIAL INSTRUCTIONS

PRE-MEDICATION

Note: pre-meds not typically indicated for Givlaari

☐acetaminophen (Tylenol) ☐500mg / ☐650mg / ☐1000mg PO

☐cetirizine (Zyrtec) 10mg PO

☐loratadine (Claritin) 10mg PO

☐famotidine (Pepcid) 20 mg IV

☐diphenhydramine (Benadryl) ☐25mg / ☐50mg ☐PO / ☐IV

☐methylprednisolone (Solu-Medrol) ☐40mg / ☐125mg IV

☐Other: _____

Dose: _____ Route: _____

LABORATORY ORDERS

☐CBC ☐at each dose ☐every _____

☐CMP ☐at each dose ☐every _____

☐LFTs ☐at each dose ☐every _____

☐Other: _____

NURSING

• Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐Opt out (I will manage any denial)

Ordering Provider (Print) **Provider Signature** **Provider NPI** **Date**

☐No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zipcode:

ARBOR INFUSION FAX NUMBERS *(Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)*

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