

## Givosiran (Givlaari®) Referral Form

Please complete the following and fax with clinical documentation  
to: 720.870.2414

Referral Process	
<b>1. PATIENT INFORMATION</b> (*indicates a required field)	<b>2. PHYSICIAN INFORMATION</b> (*indicates a required field)
Name*: _____	Physician's name*: _____
Address*: _____	License #: _____ NPI #*: _____
City*: _____ State*: _____ Zip*: _____	DEA #: _____ Email*: _____
Home Phone: _____ Mobile Phone*: _____	Address*: _____
Email*: _____ Primary language*: _____	City*: _____ State*: _____ Zip*: _____
DOB*: _____ Social Security #*: _____	Office Contact: _____
Gender*: <input type="checkbox"/> M <input type="checkbox"/> F      Height: _____ Weight*: _____	Phone*: _____ Fax*: _____ Specialty*: _____
Allergies*: _____ NKA*: <input type="checkbox"/>	
Alternate contact name: _____ Alternate contact phone: _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No* Consent to leave voice message at the patient and/or alternate contact phone	
<b>3. DIAGNOSIS</b>	
Date of diagnosis: _____	
<input type="checkbox"/> E80.21 Acute Intermittent Porphyria <input type="checkbox"/> E80.2 Other and unspecified porphyria <input type="checkbox"/> E80.29 Other porphyria	
<input type="checkbox"/> Other diagnosis(es): _____	
<b>4. INSURANCE INFORMATION</b>	
Please submit copies of the front and back of primary and secondary insurance cards with this referral.	
<b>5. PRESCRIPTION INFORMATION</b> Anticipated Start Date: _____	
<b>Prescription*</b> : GIVLAARI® injection, for subcutaneous use	
<b>Dose:</b>	
<input type="checkbox"/> GIVLAARI 2.5 mg/kg once monthly by subcutaneous injection administered by a registered nurse	
<input type="checkbox"/> GIVLAARI _____ mg/kg once monthly by subcutaneous injection administered by a registered nurse	
<b>Additional orders:</b> _____	
<b>ANAPHYLAXIS ORDERS</b>	
<b>Adults:</b> For mild reaction-administer diphenhydramine 50mg IVP/PO x 1.	
For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs.	
<input type="checkbox"/> Other: _____	
Additional Instructions: _____	
<b>6.</b>	
<b>PHYSICIAN'S SIGNATURE (required):</b> _____ <b>Date:</b> _____	