

PATIENT INFORMATION**Referral Status:** New Referral Updated Order Order RenewalPatient Full Name: _____ DOB: _____ Phone: _____ Gender: M F Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

 NKDA Allergies: _____ Existing prior authorization? Yes, (Send a copy) No (AIC will process)**Patient Status:** New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____**Patient Preferred Location:** _____**DIAGNOSIS & CLINICAL INFORMATION****ICD 10-Code & Description** (Provide full completed code) E80.21 Acute intermittent (hepatic) porphyria (AHP) E80.20 Unspecified porphyria E80.29 Other porphyria Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.

Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

Acetaminophen (Tylenol) 500mg 650mg 1000mgPO
 Cetirizine (Zyrtec) 10mgPO
 Loratadine (Claritin) 10mgPO
 Diphenhydramine (Benadryl) 25mg 50mg PO IV
 Methylprednisolone (Solu-Medrol) 40mg 125mg IV
 Other: _____ Dose: _____ Route: _____

Lab Orders

Required: Liver Function Test within 1 year

 Other: _____**Givlaari (givosiran) SC** (Select one):

Inject 2.5 mg/kg once monthly by subcutaneous injection
 Other: _____

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

Refills: zero 6 months 12 months _____ (*Prescription valid for one year, unless otherwise indicated*)

Special Instructions: _____

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

Provider Name (Print)

Provider Signature

Date