Fax: 832-895-4040
Phone: 832-895-5000
E-mail: intake@adaptivinfusion.com

adaptIV infusion

Givlaari (Givosiran)

Provider Order Form rev. 4/10/2022

PATIENT INFORMATION

Referral Status *(check one)*: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: ____________________ DOB: __________

NKDA ☐ Allergies: ____________________ Weight ______ *Please specify:* ☐ lbs ☐ kg Height: ______

Patient Status *(check one)*: ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: __________ Next Due Date: __________

ICD-10 code (required): ____________________ ICD-10 description: ____________________

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

NURSING

☐ Liver Function Test results and date

____

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

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every __________
☐ CMP ☐ at each dose ☐ every __________
☐ LFT's ☐ at each dose ☐ every __________
☐ Other: ____________________

THERAPY ADMINISTRATION

☐ **Givosiran** (Givlaari)

- Dose: 2.5mg/kg
- Frequency: once monthly
- Route: ☐ subcutaneous injection

☐ Patient required to stay for 30-min observation post procedure
☐ Patient is NOT required to stay for observation time
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ __________
(If additional treatments are needed, please submit a new order form.)

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: ____________________ Referral Coordinator Email: ____________________

Ordering Provider: ____________________ Provider NPI: ____________________

Referring Practice Name: ____________________ Phone: __________ Fax: __________

Practice Address: ____________________ City: __________ State: ______ Zip Code: __________

Provider Name (Print) ____________________ *Provider Signature* ____________________ *Date* __________

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK