MPP INFUSION CENTERS
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# GIVLAARI™ (givosiran) REFERRAL

*(* - Required Fields)*

_____ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

_____ **New Referral** _____ **Referral Renewal** _____ **Medication/Order Change**
_____ **Benefits Verification Only** _____ **Discontinuation Order**

| PATIENT INFORMATION | | | |
|---|---|---|---|
| NAME*: | | DOB*: | SEX: ☐M ☐F |
| ADDRESS: | | PHONE: | |
| WEIGHT: ☐LBS ☐KG | HEIGHT: | EMAIL: | |
| ALLERGIES: | | | |

| PHYSICIAN INFORMATION | | |
|---|---|---|
| PHYSICIAN NAME*: | | PRACTICE NAME: |
| ADDRESS: | | OFFICE CONTACT*: |
| PHONE: | FAX: | EMAIL *(FOR UPDATES)*: |

## GIVLAARI Infusion*:

*(SELECT **ONE** OF THE FOLLOWING)*

**ICD-10*:** _____

____ Dose: 2.5 mg/kg once monthly by subcutaneous injection

**Physician Signature*** _____
***NPI#**_____

**Date*(Order is Valid for One Year)**_____
*Infusion will be administered per MPP policy and protocols*

## REQUIRED DIAGNOSIS:

_____ Unspecified porphyria
_____ Acute intermittent (hepatic) porphyria
_____ Other porphyria

*STAT REASON:
(STAT request will be assessed per MPP policy and protocol)

## REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics
_____ Insurance Card/Information
_____ Clinical/Progress Notes supporting DX
_____ Current Medication List and H&P
_____ Liver Function Test (w/in 1 year)

**Last Infusion/Injection Date:** _____

**STANDING LAB ORDERS (to be drawn at clinic):** _____CMP _____CBC *Frequency_____

## FOR MPP USE ONLY

*Referral Reviewed and Accepted by:* _____ *Date approved:*_____
*Additional information needed/ notes:*

## Locations:

--------Colorado--------
___ Lakewood

---------Florida---------
___ Jacksonville
___ Kissimmee
___ Port St. Lucie
___ Suncoast
___ Winter Park

------Oklahoma--------
___ Tulsa

----------Texas----------
___ Arlington
___ Cedar Hill
___ Dallas
___ Denton
___ Ft. Worth
___ Irving
___ Rockwall
___ Southlake
___ Flower Mound
___ Plano
___ Tyler

REVISION DATE- 01/2022