Provider Order Form

GIVLAARI™ (GIVOSIRAN)

Uptiv Health

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX ☐ Baseline Liver Function Test

PATIENT

Full Name: DOB:

Mobile Phone: Height: Weight: ☐ lbs ☐ kg

Address: Email Address:

Allergies: ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Acute hepatic porphyria E80. 21 ☐ Other

PROVIDER

Provider Name: Provider NPI:

Practice Name: Referral Coordinator Name:

Practice Address:

Phone: Fax: Email:

PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO ☐ 500 mg ☐ 650 mg ☐ 1000 mg
☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV ☐ 25 mg ☐ 50 mg
☐ Methylprednisolone (Solu-Medrol) IV ☐ 40 mg ☐ 125 mg
☐ Cetrizine (Zyrtec) 10 mg PO
☐ Other: _____

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☒ Givlaari™ (Givosiran), SQ	☒ 2.5 mg /kg	☒ once monthly

Refills ☐ Zero ☐ Other ☐ _____ Order valid for 1 year unless otherwise stated. _____

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other _____

SPECIAL INSTRUCTIONS

Provider Signature Date