

# TwelveStone Health Partners

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## GIVLAARI ORDER FORM

Patient Name: _____	ICD-10 Code: _____	Therapy Status
Date of Birth: _____	Allergies: _____	<input type="checkbox"/> New Start
Weight: _____ lbs OR _____ kg		<input type="checkbox"/> Continuing Therapy: Last Dose: _____

## PROVIDER INFORMATION

Ordering Provider: _____	Provider Fax: _____
Provider NPI: _____	Provider Address: _____
Provider Phone: _____	

## MEDICATION ORDER

Givlaari	<input type="checkbox"/> 2.5mg/kg once monthly by subcutaneous injection x12 doses	<i>Please include the following lab results required for injection. If no results are available, the following labs will be drawn prior to first injection:</i> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Liver Function Panel</li> <li><input checked="" type="checkbox"/> Liver function test to be drawn prior to injection for dose 2-6</li> </ul>
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## PRE-MEDICATIONS

<b>Oral</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg _____ 650mg</li> <li><input type="checkbox"/> Loratadine: 10mg</li> <li><input type="checkbox"/> Cetirizine: 10mg</li> <li><input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg</li> <li><input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg</li> <li><input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg</li> <li><input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg</li> <li><input type="checkbox"/> Other: _____</li> </ul>	<b>IV</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Dexamethasone: _____ 4mg _____ 8mg</li> <li><input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg</li> <li><input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg</li> <li><input type="checkbox"/> Methylprednisolone: 125mg</li> <li><input type="checkbox"/> Hydrocortisone: 100mg</li> <li><input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg</li> <li><input type="checkbox"/> Other: _____</li> </ul>
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<b>LAB ORDERS</b> (please indicate any labs to be drawn and frequency)	<b>OTHER REQUIRED DOCUMENTATION</b> <p>(Please fax this signed order form, along with the following documents to 800-223-4063)</p> <ul style="list-style-type: none"> <li>• History &amp; Physical, Last Office Visit Note</li> <li>• Patient Demographics and Insurance Information</li> <li>• Medication List</li> <li>• Recent Lab Work</li> </ul>
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\*\*Surveillance lab ordering and monitoring is the responsibility of the prescriber\*\*

**By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)**

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

Prescriber Signature

Date