Ascension Rx

Givosiran (Givlaari) Subcutaneous Injection Order Form

Patient Name: _____ **Date of Birth:** _____

Patient Phone #: _____ **Date:** _____

Therapy Status: ☐ New Start ☐ Continuation ☐ Restart **Last Dose:**_____

Height (inches)	Weight (kg)	Allergies

Diagnosis

ICD-10 Code(s): _____ J Code(s): _____

Labs (Recommended to be done within 30 days of first dose)

- ☐ Labs to be reviewed or ordered by infusion center
  - ☑ Baseline
    - ☑ CMP
    - ☑ Blood Homocysteine Level
    - ☐ Folate, Vitamin B12, Vitamin B6 (recommended only if elevated homocysteine level)
    - ☐ Lipase/Amylase
  - ☐ Maintenance (every _____)
    - ☑ CMP
    - ☑ Blood Homocysteine Level
    - ☐ Lipase/Amylase
- ☐ Labs reviewed by ordering provider, ok to proceed (Labs last done on _____)
- ☐ Other: _____

Provider Information

Givosiran is a CYP1A2 and CYP2D6 inhibitor. This can significantly increase levels of CYP1A2/CYP2D6 substrates.

- ☐ CYP1A2 substrates: caffeine, clozapine, olanzapine, theophylline
- ☐ CYP2D6 substrates: Codeine, tramadol, amitriptyline, aripiprazole, atomoxetine, metoprolol, tamoxifen

Dosing Note: Weight-based dosing is based on actual body weight.

Nursing Order

- ☑ Do not administer Givosiran with an active infection, including clinically important localized infection, or if the patient is taking antibiotics for current infection.
- ☑ Assess for new-onset upper abdominal pain before each dose; if present, withhold dose and notify provider to evaluate for pancreatitis.

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☑ Pregnancy status: If uncertain, obtain HCG urine test for women 11 – 50 years prior to treatment.

Pre-Medications (Not routinely recommended, use only if clinically indicated)

- ☐ Acetaminophen 650 mg PO once
- ☐ Diphenhydramine 25 mg PO once
- ☐ Diphenhydramine 25 mg IV once
- ☐ Diphenhydramine 50 mg PO once
- ☐ Diphenhydramine 50 mg IV once
- ☐ Famotidine 20 mg IV once
- ☐ Famotidine 20 mg PO once
- ☐ Dexamethasone 20 mg IV once
- ☐ Dexamethasone 20 mg PO once
- ☐ Methylprednisolone 125 mg IV once
- ☐ Methylprednisolone 40 mg IV once
- ☐ Other: _____

Medication Orders (select loading & maintenance dose)

Standard Dose

☐ Givosiran 2.5 mg/kg (_____ mg) SQ once monthly

Reduction Dose (for patients with significant transaminase elevation)

☐ Givosiran 1.25 mg/kg (_____ mg) SQ once monthly

Refills:
(Refills for one year from date of signature unless indicated)

☐ Zero ☐ For 12 months ☐ _____

Pharmacy may substitute a biosimilar based on insurance coverage.
Pharmacy may adjust diluent, volume, and infusion duration in accordance with local practice standards.

Administration Instructions

Administer into the abdomen, thigh, or outer area of upper arm. Rotate injection sites; if the same injection site is chosen, do not inject into the same spot used for the first injection. Use 25 or 27 guage needle with ½" or ⅝" needle length.

Volume Note: If total injection volume exceeds 1.5 mL, divide equally into multiple syringes and administer at separate sites at least 2 cm apart.

Infusion Center Staff

Please fax infusion records or discharge summary to: Fax Number _____

Provider Information

Provider Signature: _____ Date: _____

Provider Printed Name: _____ Provider NPI: _____

Provider Address: _____ Phone: _____ Fax: _____

All orders are valid for 1 year from the ordered date unless otherwise indicated

7/17/2026