

AHP—Acute Hepatic Porphyria

Four simple steps to submit your referral.

1 PATIENT INFORMATION

New patient Current

Patient's first name _____
 Last name _____ Middle initial _____
 Date of birth _____ Male Female Last 4 digits of SSN _____
 Street address _____ Apt # _____
 City _____ State _____ Zip _____
 Parent/guardian (if applicable) _____
 Cell phone _____ Other phone _____
 E-mail address _____
 Patient's primary language: English Other If other, please specify _____

Please attach copies of front and back of patient's insurance cards or complete information below.

Insurance company _____
 Phone _____
 Insured's name _____
 Insured's employer _____
 Relationship to patient _____
 Identification # _____ Policy/group # _____
 Prescription card: Yes No If yes, carrier _____
 Policy # _____ Group # _____
 Is patient eligible for Medicare? Yes No
 Does patient have a secondary insurance? Yes No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____
 Prescriber's first name _____ Last name _____
 Prescriber's title _____
 If NP or PA, under direction of Dr. _____
 Office contact and title _____
 Office contact e-mail _____
 Office/clinic/institution name _____
 Clinic/hospital affiliation _____
 Street address _____ Suite # _____
 City _____ State _____ Zip _____
 Phone _____ Fax _____
 NPI # _____ License # _____
 Deliver product to: Office (as allowable by law) Patient's home Clinic
 Clinic location _____

3 CLINICAL INFORMATION

Primary ICD-10 code: E80.21 Acute intermittent (hepatic) porphyria
 E80.20 Unspecified porphyria E80.29 Other porphyria

Other drug used to treat the disease _____
 Weight _____ kg/lbs Height _____ cm/in Date recorded _____
 NKDA Known drug allergies _____
 Concurrent meds _____

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Quantity/Refills
<input type="checkbox"/> Givlaari™ (givosiran)	189 mg/mL vial	Inject _____ mg subcutaneously monthly. Note: Recommended dose is 2.5 mg/kg monthly. Patient wt (kg) _____ Date obtained _____	Dispense 1-month supply and refill x 1 year unless noted otherwise. <input type="checkbox"/> Other _____
Adverse Reaction Medications			
Epinephrine 0.3 mg auto-injector 2-pk for patients weighing greater than or equal to 30 kg. Administer intramuscularly as needed for severe anaphylactic reaction times 1 dose. May repeat 1 time.			Dispense 2-syringe pack and refill up to 1 year unless noted otherwise. <input type="checkbox"/> Other _____
Epinephrine 0.15 mg auto-injector 2-pk for patients weighing less than 30 kg. Administer intramuscularly as needed for severe anaphylactic reaction times 1 dose. May repeat 1 time.			
Ancillary Supplies			
Dispense needles, syringes, and ancillary supplies necessary to administer medication.			Refill x 1 year unless noted otherwise. <input type="checkbox"/> Other _____
Nursing Orders			
Skilled RN visits to administer medication as prescribed. Observe patient for 30 minutes post infusion for any symptoms of reaction.			

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

By signing below, I certify that the above therapy is medically necessary.

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

PHYSICIAN SIGNATURE REQUIRED

Date _____ Substitution allowed _____ Date _____ Dispense as written _____

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber. I authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

Please fax completed form to the team at **888.454.8488**.

To reach your team, call toll-free **888.454.8860**.

You can now monitor shipments and chat online if you have questions.

Go to **MyAccredoPatients.com** to log in or get started.