

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Sex:  M  F Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ lbs/kg  
Primary Language: \_\_\_\_\_ Allergies: \_\_\_\_\_  
Patient Preferred Location: \_\_\_\_\_

## DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

ICD 10 Code

E72.53 Primary hyperoxaluria

**REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

## PRESCRIPTION

### Oxlumo (lumasiran)

If patient is naive to therapy, select appropriate option or both loading and maintenance dosing.

Loading Dose: (SELECT ONE)

- Body Weight < 10 kg:** Administer 6 mg/kg by subcutaneous injection once monthly for 3 doses
- Body Weight 10 kg to < 20kg:** Administer 6 mg/kg by subcutaneous injection once monthly for 3 doses
- Body Weight > 20 kg:** Administer 3 mg/kg by subcutaneous injection once monthly for 3 doses

Maintenance:\* (SELECT ONE)

- Body Weight < 10 kg:** Administer 3 mg/kg by subcutaneous injection once monthly, beginning 1 month after last loading dose
- Body Weight 10 kg to < 20kg:** Administer 6 mg/kg by subcutaneous injection once every 3 months, beginning 1 month after last loading dose
- Body Weight > 20 kg:** Administer 3 mg/kg by subcutaneous injection once every 3 months, beginning 1 month after last loading dose

\*Supply maintenance dosing for 1 year unless otherwise noted here: \_\_\_\_\_

**Post Treatment Observations:** The patient is observed for 30 minutes following the first infusion.

**Adverse Events:** In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

**Comments:** \_\_\_\_\_

## PRESCRIBER INFORMATION

Prescriber Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
Date: \_\_\_\_\_ NPI#: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Supervising Physician: \_\_\_\_\_ (If Applicable)  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_