Oxlumo Order Form
(lumasiran)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

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.**
LAB RESULTS: **Include baseline CMP.**

PRESCRIPTION

OXLUMO (lumasiran)

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

Loading Dose (SELECT ONE)
☐ **Body Weight < 10kg:** Administer 6 mg/kg by subcutaneous injection once monthly for 3 doses
☐ **Body Weight 10kg to < 20kg:** Administer 6 mg/kg by subcutaneous injection once monthly for 3 doses
☐ **Body Weight > 20kg:** Administer 3 mg/kg by subcutaneous injection once monthly for 3 doses

Maintenance Dose* (SELECT ONE)
☐ **Body Weight < 10kg:** Administer 3 mg/kg by subcutaneous injection once monthly, beginning 1 month after last loading dose
☐ **Body Weight 10kg to < 20kg:** Administer 6 mg/kg by subcutaneous injection once every 3 months, beginning 1 month after last loading dose
☐ **Body Weight > 20kg:** 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: _____

Is the patient on any other disease modifying therapy? ☐ **Yes** ☐ **No**
If yes, please note therapy and last dose: _____

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

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

Comments:

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____