Fax: 832-895-4040
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adaptIV infusion

Oxlumo (Lumasiran)

Provider Order Form rev. 4/10/2022

PATIENT INFORMATION

Referral Status *(check one):* ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____

NKDA ☐ Allergies: _____ Weight _____ *Please specify:* ☐ lbs ☐ kg Height: _____

Patient Status *(check one):* ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

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

NURSING

☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation

THERAPY ADMINISTRATION

☐ **Lumasiran** (Oxlumo)

- ☐ Induction
  - Dose: Select one
  - ☐ 6mg/kg (Pt weight less than 20kg)
  - ☐ 3mg/kg (Pt weight 20kg and above)
  - Frequency: Once monthly for 3 doses
  - Route: Subcutaneous injection
- ☐ Maintenance (begin 1 month after the last loading dose)
  - Dose: Select one
  - ☐ 3mg/kg once monthly (Pt weight less than 10kg)
  - ☐ 6mg/kg once every 3 months (Pt weight 10 to less than 20kg)
  - ☐ 3mg/kg once every 3 months (Pt weight 20kg and above)
  - Route: ☐ Subcutaneous

☐ Patient required to stay for 30-min observation

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

_____ _____ _____

Provider Name (Print) *Provider Signature* *Date*

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK