

Connecticut
500 W Putnam Ave
Ste 435
Greenwich, CT 06830



LUMASIRAN OXLUMO®

Date: _____

PATIENT INFORMATION			
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>	
ICD-10 code (required):	ICD-10 description:		
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:		
Patient Status <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy	Last Treatment Date:	Next Due Date:	

PROVIDER INFORMATION			
Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

REFERRAL STATUS				
<input type="checkbox"/> New Referral	<input type="checkbox"/> Referral Renewal	<input type="checkbox"/> Medication/Order Change	<input type="checkbox"/> Benefits Verification Only	<input type="checkbox"/> Discontinuation Order

THERAPY ADMINISTRATION	SPECIAL INSTRUCTIONS
<p>Lumasiran (Oxlumo)</p> <p><input type="checkbox"/> Induction</p> <ul style="list-style-type: none">Dose: Select one <input type="checkbox"/> Other _____<ul style="list-style-type: none"><input type="checkbox"/> 3mg/kg (Pt weight 20kg and above)<input type="checkbox"/> 6mg/kg (Pt weight less than 20kg)Frequency: Once monthly for 3 dose <input type="checkbox"/> Other _____Route: <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other _____ <p><input type="checkbox"/> Maintenance (begin 1 month after the last loading dose)</p> <ul style="list-style-type: none">Dose: Select one<ul style="list-style-type: none"><input type="checkbox"/> 3mg/kg once monthly (Pt weight less than 10kg)<input type="checkbox"/> 6mg/kg once every 3 months (Pt weight 10 to less than 20kg)<input type="checkbox"/> 3mg/kg once every 3 months (Pt weight 20kg and above)Route: <input type="checkbox"/> subcutaneous <input type="checkbox"/> other _____ <p><input type="checkbox"/> Patient required to stay for 30-min observation post procedure</p> <p><input type="checkbox"/> Patient is NOT required to stay for observation time</p> <p><input type="checkbox"/> Refills: <input type="checkbox"/> Zero / <input type="checkbox"/> for 12 months / <input type="checkbox"/> _____ (if not indicated order will expire one year from date signed)</p>	

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____