Vermont
28 Park Ave
Suite #1A
Williston, VT 05495

ThrIVewell™ INFUSION

Mission Medical

Office: 212-803-3339 Fax : 646-768-8600

LUMASIRAN OXLUMO®

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:	Weight lbs/kg:	
Patient Status ☐ New to Therapy ☐ 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

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

THERAPY ADMINISTRATION

Lumasiran (Oxlumo)

☐ Induction
- Dose: Select one ☐Other_____
  - ☐3mg/kg (Pt weight 20kg and above)
  - 6mg/kg (Pt weight less than 20kg)
- Frequency: Once monthly for 3 dose ☐Other_____
- Route: ☐Subcutaneous injection ☐Other_____

☐ 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 than20kg)
  - ☐ 3mg/kg once every 3 months (Pt weight 20kg and above)
- Route: ☐subcutaneous ☐other_____

☐ Patient required to stay for 30-min observation post procedure
☐ Patient is NOT required to stay for observation time
☐ Refills: ☐Zero /☐ for 12 months /☐ _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____