

Hackensack
385 Prospect Avenue
Suite 101
Hackensack, NJ, 07601

Marlton
127 Church Road
Suite 203
Marlton, NJ 08053



Long Branch
422 Morris Avenue
Suite 7
Long branch, NJ 07740

Somerset
81 Veronica Avenue
Suite 202
Somerset NJ 08873

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 than 20kg)
 - ☐ 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 _____