

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



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	SPECIAL INSTRUCTIONS
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)	

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____