Lumasiran (Oxlumo)

Provider Order Form rev. 1/03/2024

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Primary hyperoxaluria type 1:

Other: Description:

THERAPY ADMINISTRATION

☑ Administer Lumasiran (Oxlumo) SQ in the abdomen, thigh, or the side or back of the upper arms. Rotate injection sites. If Injection volume is greater than 1.5ml, divide doses equally

DOSING & FREQUENCY

☐ **Loading Dose:** *(Choose one)*

- ☐ **Body Weight < 10 kg:** Administer 6 mg/kg by subcutaneous injection once monthly for 3 doses
- ☐ **Body Weight 10 kg to < 20kg:** Administer 6 mg/kg by subcutaneous injection once monthly for 3 doses
- ☐ **Body Weight > 20 kg:** Administer 3 mg/kg by subcutaneous injection once monthly for 3 doses

☐ **Maintenance Dose:** *(Choose one)*

- ☐ **Body Weight < 10 kg:** Administer 3 mg/kg by subcutaneous injection once monthly, beginning 1 month after last loading dose
- ☐ **Body Weight 10 kg to < 20kg:** Administer 6 mg/kg by subcutaneous injection once every 3 months, beginning 1 month after last loading dose
- ☐ **Body Weight > 20 kg:** Administer 3 mg/kg by subcutaneous injection once every 3 months, beginning 1 month after last loading dose

PRE-MEDICATION ORDERS

☐ Other: ________________________________

NURSING

☑ If patient is on active hemodialysis, administer after hemodialysis is administered on dialysis days

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

ADDITIONAL ORDERS

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.