

**PATIENT INFORMATION**

PATIENT NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX: ☐ M ☐ F HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ ☐ LBS ☐ KG

ALLERGIES: \_\_\_\_\_ PREFERRED CLINIC: \_\_\_\_\_

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

**DIAGNOSIS & CLINICAL DOCUMENTATION**

☐ E72.53 Primary hyperoxaluria

☐ ICD-10 CODE: \_\_\_\_\_ DESCRIPTION: \_\_\_\_\_

**REQUIRED DOCUMENTATION**

☐ Insurance  
Information

☐ List of  
Medications

☐ Tried & Failed  
Therapies

☐ Most Recent History &  
Physical

☐ AGXT genetic test

☐ Urine or plasma oxalate level

**MEDICATION ORDER**

**\*For patients Weighing 10kg to Less Than 20kg**

☐ **LOADING:** Oxlumo® (lumasiran) 6mg/kg subcutaneous injection once monthly for 3 doses

☐ **MAINTENANCE:** Oxlumo® (lumasiran) 6mg/kg subcutaneous injection every 3 months

\*Beginning 1 month following last loading dose

**\*For patients Weighing greater Than 20kg**

☐ **LOADING:** Oxlumo® (lumasiran) 3mg/kg subcutaneous injection once monthly for 3 doses

☐ **MAINTENANCE:** Oxlumo® (lumasiran) 3mg/kg subcutaneous injection every 3 months

\*Beginning 1 month following last loading dose

☒ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: \_\_\_\_\_

Patient to be observed for 30 minutes following the first administration.

In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

**PRESCRIBER INFORMATION**

PROVIDER NAME: \_\_\_\_\_ NPI #: \_\_\_\_\_

EMAIL: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

ADDRESS (INCLUDE CITY, STATE, ZIP): \_\_\_\_\_

SUPERVISING  
PHYSICIAN: \_\_\_\_\_ CONTACT NAME: \_\_\_\_\_  
(IF APPLICABLE)

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(NO STAMPS)

SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN