immersiv HEALTH

OXLUMO® ORDER FORM

FAX TO: 855.694.4656

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. Administer per protocol.
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