

## Lumasiran (Oxlumo™) Referral Form

Please complete the following and fax with clinical documentation to: 720.279.7461

Referral Process	
<b>1. PATIENT INFORMATION</b> (*indicates a required field)	<b>2. PHYSICIAN INFORMATION</b> (*indicates a required field)
Name*: _____	Physician's name*: _____
Address*: _____	License #: _____ NPI #: _____
City*: _____ State*: _____ Zip*: _____	DEA #: _____ Email*: _____
Home Phone: _____ Mobile Phone*: _____	Address*: _____
Email*: _____	City*: _____ State*: _____
Primary language*: _____	Zip*: _____
DOB*: _____ Social Security #*: _____	Office Contact: _____
Gender*: <input type="checkbox"/> M <input type="checkbox"/> F      Height: _____ Weight*: _____	Phone*: _____ Fax*: _____
Allergies*: _____	Specialty*: _____
NKA*: <input type="checkbox"/>	
Alternate contact name: _____ Alternate contact phone: _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No* Consent to leave voice message at the patient and/or alternate contact phone	
<b>3. DIAGNOSIS</b> Date of diagnosis: _____	
<input type="checkbox"/> E72.53 Primary Hyperoxaluria Type 1	
<input type="checkbox"/> Other diagnosis(es): _____	
<b>4. INSURANCE INFORMATION</b>	
Please submit copies of the front and back of primary and secondary insurance cards with this referral.	
<b>5. PRESCRIPTION INFORMATION</b> Anticipated Start Date: _____	
Prescription*: OXLUMO™ injection, for subcutaneous use	
<b>Loading Dose (to be administered by a healthcare professional)</b>	
<input type="checkbox"/> <10kg body weight: 6mg/kg once monthly by subcutaneous injection for 3 doses	
<input type="checkbox"/> 10kg to <20kg body weight: 6mg/kg once monthly by subcutaneous injection for 3 doses	
<input type="checkbox"/> 20kg body weight and above: 3mg/kg once monthly by subcutaneous injection for 3 doses	
<b>Maintenance Dose (to begin 1 month after last loading dose and administered by a healthcare professional):</b>	
<input type="checkbox"/> <10kg body weight: 3mg/kg once monthly by subcutaneous injection	
<input type="checkbox"/> 10kg to <20kg body weight: 6mg/kg once every 3 months by subcutaneous injection	
<input type="checkbox"/> 20kg body weight and above: 3mg/kg once every 3 months by subcutaneous injection	
Skilled Nursing Services Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No      Additional orders: _____	
<b>ANAPHYLAXIS ORDERS</b>	
<b>Adults:</b> For mild reaction-administer diphenhydramine 50mg IVP/PO x 1.	
For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs.	
<b>Pediatrics:</b> administer by age: For mild reaction (rash/hives) give diphenhydramine	
Age 1-5: 12.5mg IV/PO x1      Age 6-11: 25mg IV/PO x1      Age 12+: 50mg IV/PO x1	
For severe reaction (airway closure) administer epinephrine. 0.01mg/kg/dose (max 0.3mg) SubQ/IM x 1.	
If needed, repeat a second dose after 5-10 minutes for a maximum of two doses. Contact 911 and monitor vital signs.	
<b>PHYSICIAN'S SIGNATURE (required):</b> _____ <b>Date:</b> _____	