VEROS HEALTH
Excellence in Complex Care

Lumasiran (Oxlumo™) Referral Form

Please complete the following and fax with clinical documentation to: 720.870.2414

Referral Process

1. PATIENT INFORMATION (*indicates a required field)	2. PHYSICIAN INFORMATION (*indicates a required field)
Name*: _____	Physician's name*: _____
Address*: _____	License #: _____ NPI #*: _____
City*: _____ State*: _____ Zip*: _____	DEA #: _____ Email*: _____
Home Phone: _____ Mobile Phone*: _____	Address*: _____
Email*: _____ Primary language*: _____	City*: _____ State*: _____ Zip*: _____
DOB*: _____ Social Security #*: _____	Office Contact: _____
Gender*: ☐ M ☐ F Height: _____ Weight*: _____	Phone*: _____ Fax*: _____ Specialty*: _____

Allergies*: _____ NKA*: ☐
Alternate contact name: _____ Alternate contact phone: _____
☐ Yes ☐ No* Consent to leave voice message at the patient and/or alternate contact phone

3. DIAGNOSIS Date of diagnosis: _____
☐ **E72.53 Primary Hyperoxaluria Type 1**
☐ Other diagnosis(es): _____

4. INSURANCE INFORMATION
Please submit copies of the front and back of primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION Anticipated Start Date: _____
Prescription*: OXLUMO™ injection, for subcutaneous use
Loading Dose (to be administered by a healthcare professional)
☐ <10kg body weight: 6mg/kg once monthly by subcutaneous injection for 3 doses
☐ 10kg to <20kg body weight: 6mg/kg once monthly by subcutaneous injection for 3 doses
☐ 20kg body weight and above: 3mg/kg once monthly by subcutaneous injection for 3 doses

Maintenance Dose (to begin 1 month after last loading dose and administered by a healthcare professional):
☐ <10kg body weight: 3mg/kg once monthly by subcutaneous injection
☐ 10kg to <20kg body weight: 6mg/kg once every 3 months by subcutaneous injection
☐ 20kg body weight and above: 3mg/kg once every 3 months by subcutaneous injection

Skilled Nursing Services Needed? ☐ Yes ☐ No **Additional orders:** _____

ANAPHYLAXIS ORDERS
Adults: 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.
Pediatrics: 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.

PHYSICIAN'S SIGNATURE (required): _____ **Date:** _____

Prescription is valid for one year unless otherwise indicated. The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.