

OXLUMO® (lumasiran)

Patient Information

Full Name: _____ Weight: _____ lbs kg Height: _____
 DOB: _____ Allergies: NKDA _____
 Phone Number: _____
 Patient Status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

Required Documentation

- Patient Demographics and Insurance Card Medication List
 Clinical/Progress Notes Supporting Dx Recent Lab Results

Primary Diagnosis

 ICD-10 Code (required): _____
 Primary hyperoxaluria type 1 (PH1) Other: _____

Therapy Administration

Oxlumo (lumasiran) Weight-Based Dosing Regimen

Less than 10 kg:

- Induction dose:
 Oxlumo 6mg/kg subQ
 once monthly x 3 doses
 Maintenance dose:
 Oxlumo 3mg/kg subQ
 once monthly

Refills:

- x 1 year

10 kg to less than 20 kg:

- Induction dose:
 Oxlumo 6mg/kg subQ
 once monthly x 3 doses
 Maintenance dose:
 Oxlumo 6mg/kg subQ
 once every 3 months

- Other: _____

20 kg and above:

- Induction dose:
 Oxlumo 3mg/kg subQ
 once monthly x 3 doses
 Maintenance dose:
 Oxlumo 3mg/kg subQ once every 3 months

 Order valid for one year unless otherwise stated

Nursing Orders

- RN to flush and lock VAD/CVAD per violet health protocol (see violetinfusions.com/protocol for policy) RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration.
 Administer acute infusion and anaphylaxis medications per violet health protocol (see violetinfusions.com/protocol for policy) Other: Please fax alternative reaction orders, flush orders, or nursing administration orders if checking this box
 RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines.

Lab Orders

- CBC at each dose every _____ CRP at each dose every _____
 CMP at each dose every _____ Other: _____

Provider Information

Provider Name: _____ Office Contact Person: _____
 Referring Practice Name: _____ Phone Number: _____
 Referring Practice Address: _____ Fax Number: _____
 City, State, Zip: _____ Email: _____
 Provider NPI: _____
 Provider Signature: _____ Date: _____