Oxlumo® (lumasiran) Referral Form

Patient Preferred Clinic (select one): _____

VIVO infusion

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

☐ NKDA Allergies: Weight (lbs/kg): Height:

ICD-10 code (required): ICD-10 description: Last Treatment Date: Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Infusion to be administered per VIVO protocols.

REQUIRED DOCUMENTATION

- ☐ **Patient Demographics**
- ☐ **Insurance Card/Information**
- ☐ **Progress Notes Supporting DX**
- ☐ **Current Medication List and H&P**
- ☐ **Patient does not have a history of kidney or liver transplant**
- ☐ **AGXT mutation test result (if available)**
- ☐ **Urine or plasma oxalate level (if available)**

OXLUMO THERAPY ADMINISTRATION

☐ **Loading Dose**

- ☐ 6 mg/kg (patient weight less than 20 kg) monthly x 3 doses
- ☐ 3 mg/kg (patient weight 20 kg and above) monthly x 3 doses

☐ **Maintenance (begins one month after last loading dose)**

- ☐ 3 mg/kg once monthly (patient weight less than 10 kg)
- ☐ 6 mg/kg once every 3 months (patient weight 10 to less than 20 kg)
- ☐ 3 mg/kg once every 3 months (patient weight 20 kg and above)

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.

Provider Name (Print) **Provider Signature** **Date**

Have a Question? (212) 776-9090

Email Referrals To: info@specialtyinfusion.com

Fax Referrals To: (800) 540-1852

E-Prescribe: QuickRx 2nd Ave, 2355 2nd Avenue, New York NY 10035 Tel: 212-858-0659

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