

Oxlumo® (lumasiran) Referral Form



Patient Preferred Clinic (select one):

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.

OXLUMO THERAPY ADMINISTRATION

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)

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

Fax Numbers

Virginia: 804-500-5941

Nevada: 702-489-5744

Massachusetts: 800-540-1852

Colorado: 303-418-4679

New Jersey: 609-955-3711

Pennsylvania: 215-399-9244

Florida: 904-930-4211

Ohio: 216-400-0674

New York: 800-540-1852

Texas: 469-340-0044

Oklahoma: 918-770-4421

Connecticut: 203-724-4838

Have a Question? (720) 902-4111

Email Referrals To: referrals@vivoinfusion.com

**Email Specialty Referrals to:
info@specialtyinfusion.com**

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