

# Oxlumo® (lumasiran) Referral Form



**Preferred Clinic** (select one):

**PATIENT INFORMATION**

**Referral Status:**    New Referral    Updated Referral    Referral 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 Digits SSN: |

**PROVIDER INFORMATION**

|  |        |                             |                     |
|--|--------|-----------------------------|---------------------|
| Referral Coordinator Name:             |        | Referral Coordinator Email: |                     |
| Ordering Provider:                     |        | Provider NPI:               |                     |
| Referring Practice Name:               |        | Phone:                      | Fax:                |
| Practice Address:                      |        | City:                       | State:    Zip Code: |
| Physician Preferred Method of Contact: | Email: | Fax:                        | Phone:              |

**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. \*\*Order is valid for one year unless otherwise noted\*\*

|                              |                           |             |
|------------------------------|---------------------------|-------------|
| <b>Provider Name (Print)</b> | <b>Provider Signature</b> | <b>Date</b> |
|------------------------------|---------------------------|-------------|

**Email Referrals To: [referrals@vivoinfusion.com](mailto:referrals@vivoinfusion.com) OR Fax Below**

**Have a Question? Call (720) 902-4111**

|                             |                          |                            |                         |
|-----------------------------|--------------------------|----------------------------|-------------------------|
| Colorado: 303-418-4679      | Michigan: 833-957-2188   | New York: 800-540-1852     | Texas: 469-340-0044     |
| Connecticut: 203-724-4838   | Minnesota: 763-290-0903  | Ohio: 216-400-0674         | Virginia: 804-500-5941  |
| Florida: 904-930-4211       | Nevada: 702-489-5744     | Oklahoma: 918-770-4421     | Wisconsin: 414-600-5383 |
| Massachusetts: 781-202-1629 | New Jersey: 609-955-3711 | Pennsylvania: 215-399-9244 |                         |