☐ *Borough Park*
1428 36th Street
Suite 107
Brooklyn, NY 11218

☐ *Crown Heights*
555 Lefferts Avenue
Brooklyn, NY 11225

☐ *Manhattan*
57 West 57 Street
Suite 601
New York, NY 10019

☐ *Manhasset*
333 East Shore Road
Suite 201
Manhasset, NY 11030

☐ *Rockville Centre*
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

☐ *Manhattan*
225 East 70th Street
New York, NY 10021

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600
www.thrivewellinfusion.com

☐ *Queens*
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

☐ *Riverhead*
1228 E Main Street
Suite A
Riverhead, NY 11901

☐ *Holbrook/ Ronkonkoma*
233 Union Ave
Suite 207
Holbrook, NY 11741

☐ *Scarsdale*
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

☐ *Elmsford/ Terrytown*
555 Taxter Road
3rd Floor
Elmsford, NY 10523

Mission Medical

LUMASIRAN OXLUMO®

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:	Weight lbs/kg:	
Patient Status ☐ New to Therapy ☐ Continuing Therapy	Last Treatment Date:	Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:	
Ordering Provider:	Provider NPI:	
Referring Practice Name:	Phone:	Fax:
Practice Address:	City:	State: Zip Code:

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

THERAPY ADMINISTRATION

Lumasiran (Oxlumo)

☐ Induction
- Dose: Select one
  - ☐3mg/kg (Pt weight 20kg and above)
  - 6mg/kg (Pt weight less than 20kg)
- Frequency: Once monthly for 3 doses
- Route: ☐Subcutaneous injection

☐ Maintenance (begin 1 month after the last loading dose)
- Dose: Select one
  - ☐ 3mg/kg once monthly (Pt weight less than 10kg)
  - ☐ 6mg/kg once every 3 months (Pt weight 10 to less than20kg)
  - ☐ 3mg/kg once every 3 months (Pt weight 20kg and above)
- Route: ☐subcutaneous

☐ Patient required to stay for 30-min observation post procedure
☐ Patient is NOT required to stay for observation time
☐ Refills: ☐Zero /☐ for 12 months /☐ _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____