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ThriveWell
I N F U S I O N
W E S T
Office: 310-481-9944 Fax : 310-766-7001

MMI

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 ☐ Other _____
 - ☐ 3mg/kg (Pt weight 20kg and above)
 - ☐ 6mg/kg (Pt weight less than 20kg)
 - Frequency: Once monthly for 3 dose ☐ Other _____
 - Route: ☐ Subcutaneous injection ☐ Other _____
- ☐ 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 than 20kg)
 - ☐ 3mg/kg once every 3 months (Pt weight 20kg and above)
 - Route: ☐ subcutaneous ☐ other _____
- ☐ 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 _____