

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

Crown Heights
555 Lefferts Avenue
Brooklyn, NY 11225

Manhattan
57W 57Street
Suite 601
New York, NY 10019

Manhasset
339 East Shore Road
Suite 201
Manhasset, NY 11030

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

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



I N F U S I O N
Office: 212-803-3339 Fax : 646-768-8600



Manhattan
225 E 70th Street
Suite 1E
New York, NY 10021

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

Manhattan
225 East 70th Street
New York, NY 10021

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

Scarsdale
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

5 Towns
141 Washington Avenue
Cedarhurst, NY 11559

Long Beach
917 Beech Street
Long Beach, NY 11561

Riverhead
1228 E Main Street
Suite A
Riverhead, NY 11901

LUMASIRAN OXLUMO®

Date: _____

PATIENT INFORMATION			
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>	
ICD-10 code (required):	ICD-10 description:		
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:		
Patient Status <input type="checkbox"/> New to Therapy <input type="checkbox"/> 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
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> 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 _____