Chicago Illinois
4711 Golf Road
Suite 900
Skokie, IL 60076

Office: 212-803-3339 Fax : 646-768-8600

REJUVEINATE

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 than20kg)
  - ☐ 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 ______________