Provider Order Form

OXLUMO® (LUMASIRAN)

Uptiv Health

PATIENT

Full Name: _____ DOB:

Mobile Phone: _____ Weight: ☐ lbs ☐ kg

Allergies: _____ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Primary hyperoxaluria E72.53 ☐ Other: _____

PROVIDER

Provider Name: _____ Provider NPI: _____

Practice Name: _____ Referral Coordinator Name: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO ☐ 500 mg ☐ 650 mg ☐ 1000 mg
☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV ☐ 25 mg ☐ 50 mg
☐ Methylprednisolone (Solu-Medrol) IV ☐ 40 mg ☐ 125 mg
☐ Cetrizine (Zyrtec) 10 mg PO
☐ Other _____

THERAPY ADMINISTRATION

Medication	Body Weight	Induction Dose	Maintenance Dose (beginning 1 month after the last loading dose)
☒ OXLUMO® (Lumasiran), SQ	☐ Less than 10 kg	☐ 6 mg/kg once monthly x 3 doses	☐ 3 mg/kg once monthly
	☐ 10 kg to less than 20 kg	☐ 6 mg/kg once monthly x 3 doses	☐ 6 mg/kg once every 3 months
	☐ 20 kg and above	☐ 3 mg/kg once monthly x 3 doses	☐ 3 mg/kg once every 3 months

Refills ☐ Zero ☐ 12 months ☐ _____ Order valid for 1 year unless otherwise stated. _____

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

☐ CBC	☐ at each dose	☐ every _____
☐ CMP	☐ at each dose	☐ every _____
☐ CRP	☐ at each dose	☐ every _____
☐ Other _____	☐ at each dose	☐ every _____

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX ☐ AGXT mutation test result (if available)
☐ Patient does not have a history of kidney or liver transplant ☐ Urine or plasma oxalate level (if available)

Provider Signature _____ Date _____