



175 Memorial Highway, Suite 1-1
New Rochelle, NY
1080

914-460-489
fuse@fuseinfusion.com
914-460-4571

_____ ok the switch to biosimilar if insurance formulary prefers

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

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 than 20kg)
 - 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 _____