# OXLUMO (LUMASIRAN) INJECTION ORDERS

**P:** 331-236-0610 | **F:** 331-314-8989

## PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 331-314-8989

| | | | | | |
|---|---|---|---|---|---|
| Name: | | DOB: | | Gender: □ Female □ Male | |
| Address: | | City: | State: | ZIP: | |
| Phone: | Email: | Height: | □ inches □ cm | Weight: | □lbs. □ kg |
| Allergies: | | | | | |
| **Diagnosis Code ICD-10 (required):** | | **Diagnosis Description:** | | | |
| Patient Status: □ New to Therapy □ Continuing Therapy | | Next Treatment Date: | | | |

## PHYSICIAN INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| Prescriber Name: | | Phone: | | Fax: | |
| Office Contact: | | | | Email: | |
| Address: | | City: | State: | ZIP: | |
| NPI #: | DEA#: | | | Tax ID: | |

## INSURANCE INFORMATION (or attach copy of cards)

| | | |
|---|---|---|
| Primary Insurance: | Policy #: | Group #: |
| Secondary Insurance: | Policy #: | Group #: |

## PRESCRIPTION INFORMATION (or attach a copy of the prescription)

| Drug | Dosing | Refills |
|---|---|---|
| **Oxlumo** (lumasiran) | Adult dosing:<br>□New start: 3mg/kg subQ once monthly x 3 months, then 3mg/kg subQ once every 3 months beginning 1 month after the last loading dose<br><br>□3mg/kg subQ every 3 months<br><br>□Other: _____ | □ x 1 year<br><br>□ _____ |

Other orders: _____

Lab orders: _____ Lab Frequency: _____

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. □ Dispense as written

## PRESCRIBER SIGNATURE

By signing this form and utilizing our services, you are authorizing *LIVbetter Infusions.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

**Prescriber Signature: X** **Date:**

# COMPREHENSIVE SUPPORT FOR OXLUMO (LUMASIRAN) THERAPY

## PATIENT INFORMATION

Name: DOB:

## REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

☐ Include signed and completed order (MD/prescriber to complete page1)

☐ Include patient demographic information and insurance information

☐ Include patient's medication list

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

**Please answer the following**:

- Does the patient have molecular genetic test results demonstrating a pathogenic variant in the alanine:glyoxylate aminotransferase (AGXT) gene? □ Yes □ No
- Does the patient have liver enzyme analysis results demonstrating absent or significantly reduced alanine:glyoxylate aminotransferase (AGT) activity? □ Yes □ No
- Do lab results show elevated urinary oxalate, urinary oxalate:creatinine ratio, or plasma oxalate levels prior to initiating therapy? □ Yes □ No
- Does the patient have a history of a liver transplant? □ Yes □ No
- Will therapy be used in combination with pyridoxine? □ Yes □ No

If no, please explain _____

☐ Include labs and/or test results to support diagnosis

☐ Other medical necessity: _____