INTRAMED Plus
infusion services

OXLUMO®

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD-10 Code):

Primary Diagnosis: _____ Primary Hyperoxaluria Type 1 ICD-10 Code: E72.53

_____ Other: _____ ICD-10 Code: _____

Allergies: _____ (or attach list)

3. Clinical Information — Please fax with Infusion Order Form:

- Clinical documentation supporting primary diagnosis
- Recent Lab/Test Results including:
  - o AGXT genetic test
  - o Urine or plasma oxalate level
- Medication List
- Continuation of therapy: Oxlumo start date: _____
  - o Attach notes showing a reduction in urinary or plasma oxalate levels compared to baseline

Patient
Weight: _____ lbs.
Height _____ in.

4. Drug Order:

OXLUMO® (Lumasiran) J Code: J0224

❑ **New Start / Loading Dose**

Patient Weight	Dose	Directions	Doses/Refills
❑ Less than 10 kg	6 mg/kg	Inject subcutaneously once monthly	Doses authorized: 3 (three)
❑ 10 kg to < 20 kg	6 mg/kg		
❑ 20 kg and above	3 mg/kg		

❑ **Maintenance Regimen** (to be initiated 1 month following the final administration of the loading dose):

Patient Weight	Dose	Directions	Doses/Refills
❑ Less than 10 kg	3 kg/kg	Inject subcutaneously once monthly	Refills: _____ (Recommend 11)
❑ 10 kg to < 20 kg	6 mg/kg	Inject subcutaneously every 3 months	Refills: _____ (Recommend 3)
❑ 20 kg and above	3 mg/kg		

Pre-Medication Orders: _____

No Pre-medications are recommended based on manufacturer guidelines.

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing our services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____

Dispense as written Substitution permitted

Printed Physician's Name with Credentials: _____ Phone #: _____

FAX ALL INFORMATION
CENTRAL FAX 803.999.1754

INFUSION CENTER LOCATIONS
BERKELEY CHARLESTON COLUMBIA GREENVILLE
CENTRAL INTAKE PHONE 803.999.1760