



A Carelon Company

OXLUMO (LUMASIRAN) INJECTION ORDERS

P: 877-365-5566 | **F:** 855-889-2946

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Address:		City:	State:	ZIP:
Phone:	Email:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> 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: <input type="checkbox"/> 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 <input type="checkbox"/> 3mg/kg subQ every 3 months <input type="checkbox"/> Other: _____	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____

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 Paragon Healthcare, Inc. 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:

PATIENT INFORMATION

Name:

DOB:

REQUIRED DOCUMENTATION FOR REFERRAL CROSSING & INSURANCE APPROVAL

- Include signed and completed order (MD/prescriber to complete page 1)
- 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: _____