



Patient Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_\_\_

Date of Last Infusion: \_\_\_/\_\_\_/\_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Infusion Location: (state and Site) \_\_\_\_\_

### Oxlumo (lumasiran) Infusion Orders

Diagnosis: please add the ICD-10 code

_____ Primary hyperoxaluria type 1
_____ OTHER: _____

Lab orders:

Other: \_\_\_\_\_

Administer Oxlumo		Patient Weight _____ Kg	
Body Weight	Loading Dose	Maintenance Dose	
<input type="checkbox"/> Less than 10kg	<input type="checkbox"/> 6 mg/kg once monthly for 3 doses Sub-q	<input type="checkbox"/> 3mg/kg once monthly, beginning 1 month after the last loading dose sub-q	
<input type="checkbox"/> 10kg to less than 20kg	<input type="checkbox"/> 6mg/kg once monthly for 3 doses sub-q	<input type="checkbox"/> 6mg/kg once every 3 months (quarterly), beginning 1 month after the last loading dose sub-q	
<input type="checkbox"/> 20mg and above	<input type="checkbox"/> 3mg/kg once monthly for 3 doses sub-q	<input type="checkbox"/> 3mg/kg once every 3 months (quarterly) beginning 1 month after the last loading dose sub-q	

- Administer after hemodialysis or administered on dialysis days
- Administer subcutaneously only
- If injection volume is greater than 1.5ml, divide doses equally
- Administer in the abdomen, thigh, or the side or back of the upper arms. Rotate injection sites
- If infusion-related reaction occurs, stop infusion & follow Hypersensitivity Reaction Management Protocol

Provider name (print): \_\_\_\_\_ Date: \_\_\_\_\_

Provider signature: \_\_\_\_\_ Time: \_\_\_\_\_