TwelveStone Health Partners
Fax Referral To:
(800) 223-4063
Direct Phone: (615) 278-3350
Toll Free: (844) 893-0012

OXLUMO ORDER FORM

Date: _____

Patient Name: _____

Date of Birth: _____

ICD-10 Code: _____

Allergies: _____

Weight: _____ lbs OR _____ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

Provider Information

Ordering Provider: _____

Provider NPI: _____

Provider Phone: _____

Provider Fax: _____

Provider Address: _____

MEDICATION ORDER

☐ Oxmlumo

☐ Weight less than 10kg: Inject Oxlumo 6mg/kg once monthly for a total of three doses, followed by Oxlumo 3mg/kg once monthly per protocol.

☐ Weight 10kg to less than 20kg: Inject Oxlumo 6mg/kg once monthly for a total of three doses, followed by Oxlumo 6mg/kg once every three months per protocol.

☐ Weight 20kg and above: Inject Oxlumo 3mg/kg once monthly for a total of three doses, followed by Oxlumo 3mg/kg once every three months per protocol.

Refills x one year from date of signature unless indicated below.

☐ _____ Refills

PRE-MEDICATIONS

Oral

☐ Acetaminophen: _____ 325mg _____ 500mg _____650mg
☐ Loratadine: 10mg
☐ Cetirizine: _____10mg
☐ Diphenhydramine: _____ 25mg _____50mg
☐ Famotidine: 20mg _____40mg
☐ Ibuprofen: _____ 200mg _____400mg _____600mg
☐ Ondansetron: _____ 4mg _____ 8mg
☐ Other: _____

IV

☐ Dexamethasone: _____4mg _____8mg
☐ Diphenhydramine: _____ 25mg _____50mg
☐ Famotidine: _____20mg _____40mg
☐ Methylprednisolone: _____125mg
☐ Hydrocortisone: _____ 100mg
☐ Ondansetron: _____ 4mg _____ 8mg
☐ Other: _____

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering, and monitoring is the responsibility of the prescriber

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written:

_____ _____
Prescriber Name Date

Substitution Allowed:

_____ _____
Prescriber Name Date