TwelveStone Health Partners

Fax Referral To:

(800) 223-4063

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

OXLUMO ORDER FORM

Date: ______________________	ICD-10 Code: ______________________
Patient Name: ______________________	Allergies: ______________________
Date of Birth: ______________________	Weight: ________lbs OR ________kg

Therapy Status	Provider Information
☐ New Start ☐ Continuing Therapy: Last Dose: ______________________	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
- ☐ Hydrocortosone: ______ 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:	Substitution Allowed:
______________________ ____________ Prescriber Name Date	______________________ ____________ Prescriber Name Date