Cumberland Vital Care
Fax Referral To:
(931) 456-4857
Direct Phone: (931) 456-0680

CVC CUMBERLAND VITAL CARE
PHARMACEUTICAL COMPOUNDING & INFUSION SERVICES

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
- ☐ 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 Ofice 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