

Westerville  
575 Copeland Mill Road  
Suite# 2F  
Westerville, Ohio 43081



Lancaster  
2405 Columbus Street  
Suite# 210  
Lancaster, Ohio 43130

# LUMVOA (veligrotug-vvze)

Provider Order Form

Date: \_\_\_\_\_

## PATIENT INFORMATION

Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
Address:	Phone #:	
<input type="checkbox"/> NKDA	Allergies:	

## REFERRAL STATUS

New Referral    Referral Renewal    Medication/Order Change    Benefits Verification Only    Discontinuation Order

## PHYSICIAN INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: _____ Fax: _____
Practice Address:	City: _____ State: _____ Zip Code: _____

### Diagnosis: Thyroid Eye Disease

- ICD - E05.00\*: \_\_\_\_\_  
 Other: \_\_\_\_\_

### PRE-MEDICATION ORDERS

- Acetaminophen (Tylenol)    500mg /  650mg /  1000mg PO  
 Cetirizine (Zyrtec) 10mg PO  
 Loratadine (Claritin) 10mg PO  
 Diphenhydramine (Benadryl)  25mg /  50mg    PO /  IV  
 Methylprednisolone (Solu-Medrol)  40mg /  125mg IV  
 Hydrocortisone (Solu-Cortef)  100mg IV  
 Other: \_\_\_\_\_  
Dose: \_\_\_\_\_ Route: \_\_\_\_\_  
Frequency: \_\_\_\_\_

### THERAPY ADMINISTRATION

**Lumvoa** (veligrotug-vvze)

Weight lbs/kg: \_\_\_\_\_

**LUMVOA Dose**

- Dose: 10 mg/kg IV  
▪ Frequency: Every 3 weeks  
▪ Route: IV  
▪ Total: 5 infusions

**Infusion Duration:**

- First infusion: 45 minutes
- If tolerated, subsequent infusions: minimum 30 minutes
- If not tolerated: maintain 45 minutes

### SPECIAL INSTRUCTIONS

NOTES/ADDITIONAL COMMENTS:

### ORDERING PROVIDER

Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

Provider \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_