Vermont
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Williston, VT 05495

ThrIVewell™ INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

LUMVOA (veligrotug-vvze)

Provider Order Form

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
Address:	Phone #:	
☐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 _____