LUMVOA
(veligrotug-vvze)

FLEXCARE INFUSION CENTERS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • History & Physical • Patient Demographics • Medication List • Recent Thyroid Panel • Neg Pregnancy Test

• CAS Score: _____ • Patient Ethnicity (can affect proptosis requirements): _____

• Endocrinologist's Name: _____ • Opthalmologist's Name: _____

PRIMARY DIAGNOSIS

☐ E05.00 Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm
☐ H05.831 Thyroid orbitopathy, right orbit
☐ H05.832 Thyroid orbitopathy, left orbit
☐ H05.833 Thyroid orbitopathy, bilateral
☐ H05.839 Thyroid orbitopathy, unspecified orbit
☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

*HgbA1c will be drawn at baseline and every 3 months while on therapy, per FlexCare protocol (no cost to payor or patient).
hCG will be performed at each visit for patients who may become pregnant.

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Lumvoa

☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

**Patients with pre-existing diabetes should be under appropriate glycemic control before receiving Lumvoa.

☐ Lumvoa 10mg/kg (_____mg) IV every 3 weeks for five treatments

☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)

☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____
Provider Signature Date

FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals