LUMVOA™ (VELIGROTUG-VVZE) PRESCRIBER ORDER FORM

Patient Name:	Date of Birth:	Gender:
Address:		

Phone:	Height:	☐ inches ☐ cm	Weight:	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description: Thyroid eye disease	ICD-10 Code: E05.00

Lumvoa™ (Veligrotug-vvze) Prescription

LUMVOA™ (Veligrotug-vvze)

Option Care Health to initiate services beginning with Dose No. _____ as indicated below:

- Dose 1: Infuse 10 mg/kg IV over 45 minutes
- Doses 2-5 (3 weeks after Dose 1): Infuse 10 mg/kg IV over 30 minutes every 3 weeks x 4 doses. (If not well tolerated, the minimum time for infusions should remain at 45 minutes)

Dispense quantity sufficient of LUMVOA™ 500 mg (50mg/mL) single dose vials for each dose. Discard any unused vial contents.
Prescriber to assess hearing before, during, and after treatment.

Ancillary Orders

Anaphylaxis Kit

If this is a 1st infusion dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?
☐ Yes ☐ No

Dosage: ☐ Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
☐ Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg – 25mg max dose) IV or IM; repeat x 1 in 15 min PRN no improvement.
☐ 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Pre-Medication Orders

☐ Acetaminophen 650 mg PO 30 min before infusion. Patient may decline.
☐ Diphenhydramine 25 mg PO 30 min before infusion. Patient may decline.
☐ Other: _____

IV Flush Orders

☐ Peripheral: 0.9% Sodium Chloride 3 to 5 mL pre-/post-use.
☐ Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw.
Heparin (100 unit/mL) 3 to 5 mL post-use.
For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

☐ No labs ordered at this time.
☐ Other: _____

Skilled nurse to assess and administer and/or teach self-administration where appropriate via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.
If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:	Phone:	Fax:
Address:	**NPI:**	

City, State:	Zip:	Office Contact:

Fax completed form, insurance information, and clinical documentation to: (844) 767-7500

Not valid for use for patients residing in Arizona, New York, and Wisconsin

