immersiv HEALTH

LUMVOA® ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

☐ E05.00 Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm

☐ ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

☐ Insurance Information

☐ List of Medications

☐ Tried & Failed Therapies

☐ Most Recent History & Physical

☐ CAS Score *(as required by payor)*

☐ Thyroid Panel

PATIENTS WITH PRE-EXISTING DIABETES SHOULD BE UNDER APPROPRIATE GLYCEMIC CONTROL BEFORE RECEIVING LUMVOA®

MEDICATION ORDER

☑ Lumvoa® _____ mg (10 mg/kg) in 250 mL NS via IV every 3 weeks for a total of 5 infusions.

- Infusion 1: infused over 45 minutes
- Infusions 2-5: infused over 30-45 minutes as tolerated

☐ **REFILLS:** _____

Patient to be observed for 30 minutes following the first administration. Administer per protocol.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRE-MEDICATIONS

PO

☐ Acetaminophen: 650 mg

☐ Cetirizine: 10 mg

☐ Diphenhydramine: 25 mg

IV

☐ Methylprednisolone: 125 mg

☐ Diphenhydramine: 25 mg

☐ **OTHER:** _____ ☐ PO ☐ IV

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ **CONTACT NAME:** _____
(IF APPLICABLE)

SIGNATURE: _____ | _____ **DATE:** _____
(NO STAMPS)

SUBSTITUTION PERMITTED DISPENSE AS WRITTEN