LUMVOA

Orders

VELIGROTUG-VVZE

Email: intake@infuseoneohio.com
Fax: (614) 929-7199
Phone: (614) 929-3349

INFUSE ONE OHIO

Locations: ☐ Dublin, OH ☐ Lancaster, OH

PATIENT INFORMATION

Patient Name _____ **Date of Birth** _____ **Gender** ☐ M ☐ F

Patient Address / City / State / ZIP _____ **Phone** _____

DIAGNOSIS

PROVIDE ICD-10 CODE

☐ Thyroid eye disease (TED) - regardless of activity or duration

ICD-10 _____

☐ Active TED ☐ Chronic TED ☐ Activity/duration not specified

Other ICD-10 _____

PRE-MEDICATIONS

OPTIONAL - CONSIDER AFTER PRIOR INFUSION REACTION

☐ None ☐ Acetaminophen _____ mg PO ☐ Diphenhydramine _____ mg ☐ PO ☐ IV

☐ Corticosteroid _____ Dose _____ ☐ Other _____

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DOSAGE & FREQUENCY

Weight (kg) _____ **Dose (mg)** _____ **Vials** _____

☐ 10 mg/kg IV every 3 weeks for 5 total infusions

Dilute calculated dose in a 250 mL bag of 0.9% sodium chloride.

☐ First infusion: administer IV over 45 minutes ☐ Subsequent infusion: at least 30 minutes if tolerated; otherwise 45 minutes

Do not administer by IV push/bolus or infuse concomitantly with other agents.

REQUIRED CLINICAL REVIEW

COMPLETE BEFORE AND DURING THERAPY

☐ Blood glucose and hyperglycemia symptoms assessed before infusion

☐ Diabetes/hyperglycemia appropriately controlled, if applicable

☐ Hearing assessed before, during, and after treatment

☐ IBD history/symptoms assessed; discontinue if IBD is suspected

☐ Pregnancy test completed before initiation, if applicable

☐ Contraception counseling completed through 6 months after last dose

Monitor for infusion reactions during and soon after infusion; manage per protocol.

Post-infusion observation: _____ minutes

NOTES

ORDERING PROVIDER

Provider NPI _____ **Phone** _____ **Fax** _____

Provider Name _____

Provider Address _____

Prescriber Signature _____ **Date** _____