Lumvoa (veligrotug-vvze)

MIC | METRO INFUSION CENTER

REFERRAL STATUS: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Infusion Office Preference: _____

PATIENT INFORMATION			
Date:	Patient Name:		DOB:
☐ NKDA Allergies:		Weight (lbs / kg):	Height:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy - Last Treatment Date:			Next Due Date:
PROVIDER INFORMATION			
Office Contact Name:	Office Email:		
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		
DIAGNOSIS AND ICD 10 CODE			
☐ Thyroid Eye Disease **ICD 10 Code: E05.00** ☐ _____ICD 10 Code: _____			
REQUIRED DOCUMENTATION/Testing			
☐ This signed order form by the provider ☐ Patient demographics AND insurance info ☐ Clinical/Progress notes supporting primary dx	☐ Physician to monito		
List Tried & Failed Therapies 1)	2)		
PREMEDICATION ORDERS			
☐ acetaminophen (Tylenol) PO ☐ 500mg ☐ 650mg ☐ 1000mg ☐ diphenhydramine (Benadryl) **PO / IV** ☐ 25mg ☐ 50mg (if route is not circled PO will be administered) ☐ methylprednisolone (Solu-Medrol) IV ☐ 60mg ☐100mg ☐ 125mg ☐ _____ mg ☐ Other:			
MEDICATION ORDERS			
☒ Lumvoa 10 mg/kg IV every 3 weeks x 5 infusions			

SPECIAL INSTRUCTIONS
☒ Patients blood sugar has been under control

**Referring physician to monitor patient for signs and symptoms of inflammatory bowel disease (IBD)*

**Referring physician to assess patient's hearing before, during, and after treatment*

Provider Name (Print) **Physician Signature:** **Date:**

Fax referral to 866-507-1164 or email to bionurses@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Created 7/2/26