INTRAMED Plus
infusion services

LUMVOA™

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD-10 Code):

Primary Diagnosis: _____ Thyroid Eye Disease (TED) ICD-10 Code: E05.00

_____ Other: _____ ICD-10 Code: _____

Allergies: _____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical documentation supporting primary diagnosis
- Recent Lab/Test Results including:
  - o A1C to reflect baseline glycemic control
- Medication List

Patient
Weight: _____ lbs.
Height: _____ in.

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4. Drug Order: **Lumvoa™ (veligrotug-vvze)** **J Code: J___**

Administer 10 mg/kg intravenously once every 3 weeks for a total of 5 infusions

- Dose 1: infuse over 45 minutes
- Doses 2-5 (3 weeks after Dose 1): infuse over 30 minutes (If tolerated, otherwise remain at 45 minutes)

Doses Authorized: 5 (five)

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

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: _____

❑ **Lab Orders:** _____

Skilled nurse to administer doses by the ordered route (IV or SUBQ). For SUBQ administration, nurse to assess, administer, and/or teach self-administration where appropriate, and provide ongoing support as needed.

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.
Anaphylaxis Kit:

- 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) 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.

By signing this form and utilizing our services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name with Credentials: _____ Phone #: _____

FAX ALL INFORMATION	CENTRAL INTAKE PHONE	
CENTRAL FAX **803.999.1754**	**803.999.1750**	Access Intramed Plus prescription order forms here.

AUGUST 2026