InfuCare Rx®

Lumvoa™ Enrollment Form

Fax Referral To: 877-277-9155
Phone: 877-828-3940
referrals@infucarerx.com
www.infucarerx.health

Please cut along the dotted lines before submitting to a pharmacy.

Date Required: _____ Ship To: ☐ Patient ☐ MD Office ☐ Other: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: _____
Emergency Contact: _____ Phone: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA #: _____ NPI #: _____
Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
Secondary Insurance: _____ ID: _____ Group: _____
Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

DIAGNOSIS

☐ E05.00 Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm (hyperthyroidism)
☐ Other: _____

MEDICAL HISTORY

Patient Weight: _____ kg ☐ lbs ☐ Height: _____ ☐ cm ☐ in
Allergies: _____
Line Access: ☐ Peripheral ☐ Port
Delivery Method: ☐ Infusion Pump ☐ Other: _____
Nursing Coordination:
☐ Pharmacy to coordinate home health nursing visit as necessary: ☐ Yes ☐ No
☐ Home health nursing coordination not necessary. Reason:
☐ MD office to administer to patient
☐ Home health nursing already coordinated
(If applicable) Is the patient pregnant or planning to be pregnant? ☐ Yes ☐ No
Is the patient diabetic? ☐ Yes ☐ No
Does the patient have pre-existing or long term hearing loss? ☐ Yes ☐ No
Lab Orders: _____

PRESCRIPTION INFORMATION

Lumvoa™ (Veligrotug-vvze) Prescription:	Quantity:	Refills:
Infuse 10 mg/kg IV every 3 weeks for a total of 5 infusions. Infuse IV over 45 minutes for the first infusion. If well tolerated, subsequent infusions can be infused over a minimum of 30 minutes. If not well tolerated, the minimum time for subsequent infusions should remain at 45 minutes.		

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol

Peripheral:
☐ NaCl 0.9% 5mL
☐ NaCl 0.9% 10mL

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

Premedications & Other Medications

☐ Infusion supplies as per protocol
☐ Anaphylaxis Kit orders as per protocol
☐ Acetaminophen 650 mg PO prior to infusion
☐ Diphenhydramine 25 mg PO
☐ Other: _____

ADDITIONAL COMMENTS:

Prescriber Signature: _____ **Date:** _____

Revised 7 August 2026