Physician Infusions Lumvoa™ Referral Form

Patient Information

Patient Name: DOB: Height: Weight:

Address: Phone: Email:

Insurance Information (Include a copy of the front and back of patient's insurance card)

Primary: Policy #: Group #: Ins Phone:

Secondary: Policy #: Group #: Ins Phone:

Referring Provider Office Information

Provider Name: NPI: Office Name:

Office Address:

Office Contact: Phone: Fax: Email:

Pre-medications

☐ Physician Infusions to order pre-medications per standard infusion protocols/procedures

-- OR --

☐ _____ mg Acetaminophen PO ☐ _____ mg Diphenhydramine PO

☐ _____ mg Cetirizine PO ☐ _____ mg Diphenhydramine IV

☐ _____ Other IV/PO ☐ _____ mg Solumedrol IV

Required Labs

☐ Physician Infusions to order baseline labs/glucose screenings and calculate CAS score

-- OR --

☐ CBC, CMP, Quantiferon TB, TSH, Free T3, Free T4

Laboratory Frequency:

Prescription

Diagnosis Code: Diagnosis Description:

Allergies:

Medication: Lumvoa Route: IV First Infusion? Y/N Last Infusion Date (If applicable):

Frequency: Every 3 weeks Total Infusions: 5 How many infusions has the patient had?: ___ out of 5

Administration: Dilute in 250 mL bag of 0.9% Sodium Chloride.

First infusion (45 minutes): 10 mg/kg **Infusion 2-5 (30 minutes)**: 10 mg/kg

Is the patient required to stay for a 30-minute observation period? Y/N

☑ Provide nursing care per Physician Infusions policies and procedures, including but not limited to post-infusion observation and management of adverse reactions.

Special Instructions

Please send completed referral form, office notes, labs/imaging results (including TB result and date if applicable) to Physician Infusions fax (512) 354-4938.

Prescriber Signature: _____ Prescriber Printed Name: _____ Date: _____