Natalizumab Referral Form

Preferred Clinic (select one): _____

VIVO infusion®

PATIENT INFORMATION

☐ New Referral ☐ Updated Referral ☐ Referral Renewal

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

☐ NKDA Allergies: Weight (lbs/kg): Height:

ICD-10 Code (MS-SEE BELOW): ICD-10 Description: Last Treatment Date: Last 4 Digits SSN:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

Physician Preferred Method of Contact: ☐ Email: ☐ Fax: ☐ Phone:

STANDING ORDERS

☑ Infusion to be administered per Vivo protocols.

LABORATORY ORDERS

- ☐ CBC w/ diff every _____
- ☐ CMP every _____
- ☐ Stratify JCV Antibody Test every 6 months
- ☐ Vitamin D-25-OH every 12 months

***Vivo Infusion will perform pregnancy screening prior to every infusion per Vivo policy*

PREMEDICATIONS

- ☐ acetaminophen (Tylenol) ☐ 500 mg ☐ 650 mg ☐ 1000 mg PO
- ☐ cetirizine (Zyrtec) 10mg PO
- ☐ loratadine (Claritin) 10mg PO
- ☐ diphenhydramine (Benadryl) ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV
- ☐ methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV
- ☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV

Other: _____

Dose: _____ Route: _____

REQUIRED DOCUMENTATION

- ☐ **Patient Demographics**
- ☐ **Insurance Card/Information**
- ☐ **Progress Notes Supporting DX**
- ☐ **Current Medication List and H&P**
- ☐ **JCV Antibody**

Current MS Drug _____

NATALIZUMAB ADMINISTRATION: Payors may require patients start therapy with a natalizumab biosimilar. Choose ONE of these two options:

- ☐ Infuse **natalizumab** or **natalizumab biosimilar** as required by patient's insurance.
- ☐ Do not use biosimilar (subject to prior authorization).
- ☐ Dose: 300 mg IV every 4 weeks

REQUIRED ICD-10 CODE

- ☐ G35.A Relapsing-remitting multiple sclerosis
- ☐ G35.B0 Primary progressive multiple sclerosis, unspecified
- ☐ G35.B1 Active primary progressive multiple sclerosis
- ☐ G35.B2 Non-active primary progressive multiple sclerosis
- ☐ G35.C0 Secondary progressive multiple sclerosis
- ☐ G35.C1 Active secondary progressive multiple sclerosis
- ☐ G35.C2 Non-active secondary progressive multiple sclerosis
- ☐ G35.D Multiple sclerosis, unspecified

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

Email Referrals To: referrals@vivoinfusion.com OR Fax Below

Have a Question? Call (720) 902-4111

Colorado: 303-418-4679	Michigan: 833-957-2188	New York: 800-540-1852	Texas: 469-340-0044
Connecticut: 203-724-4838	Minnesota: 763-290-0903	Ohio: 216-400-0674	Virginia: 804-500-5941
Florida: 904-930-4211	Nevada: 702-489-5744	Oklahoma: 918-770-4421	Wisconsin: 414-600-5383
Massachusetts: 781-202-1629	New Jersey: 609-955-3711	Pennsylvania: 215-399-9244	

Order is valid for one year unless otherwise noted

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