

Pombiliti™ (cipaglusidase alfa-atga) & Opfolda™ (miglustat) Referral Form



Patient Preferred Clinic (select one):

PATIENT INFORMATION

Referral Status:

New Referral

Updated Order

Order Renewal

DOB: _____ Patient Name: _____ Patient Phone: _____
 Patient Address: _____ Patient Email: _____
 NKDA Allergies: _____ Weight (lbs/kg): _____ Height: _____
 ICD-10 code (required): _____ ICD-10 description: _____ Last Treatment Date: _____ Last 4 SSN: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____
 Ordering Provider: _____ Provider NPI: _____
 Referring Practice Name: _____ Phone: _____ Fax: _____
 Practice Address: _____ City: _____ State: _____ Zip Code: _____

NURSING

Infusion to be administered per Vivo protocols.

POMBILITI THERAPY ADMINISTRATION

20 mg/kg intravenously every other week.

LABORATORY ORDERS

CBC At each dose Every _____
 CMP At each dose Every _____

OPFOLDA THERAPY ADMINISTRATION

Weight greater than or equal to 50 kg: 260 mg PO 1 hour prior to each Pombiliti dose.

OTHER _____

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

Weight greater than or equal to 40 kg but less than 50 kg: 195 mg PO 1 hour prior to each Pombiliti dose.

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: _____

Other: _____

Patient to supply Opfolda and bring to each appointment.

REQUIRED DOCUMENTATION

Patient Demographics

Insurance Card/Information

Progress Notes Supporting DX

Current Medication List and H&P

GAA enzyme assay or genetic confirmation test

Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted*

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: 800-540-1852	New Jersey: 800-540-1852	Pennsylvania: 215-399-9244	