IVIG Referral Form

Preferred Clinic (select one): WI-Sun Prairie

☐ New Referral ☐ Updated Referral ☐ Referral Renewal

PATIENT INFORMATION

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 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 _____

☐ OTHER _____

PREMEDICATIONS

☐ acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV

☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV

☐ Other: _____

Dose: _____ Route: _____

PRE/POST HYDRATION ORDERS (optional)

IVIG ADMINISTRATION

IVIG _____ gm/kg/day IV x _____ days every _____weeks

IVIG _____ gm/kg IV divided over _____ days every _____weeks

IVIG _____ grams IV x _____ days every _____weeks

Calculated Dose (to be done by Vivo Infusion) _____

Dose will be rounded up to to nearest 5-gram vial

Please select preferred product (if no product selected, Vivo Infusion will select based upon payer requirements, indication or formulary preference):

☐ Gammagard ☐ Bivigam ☐ Alyglo

☐ Privigen ☐ Asceniv ☐ Octagam 10% (ITP, dermatomyositis)

☐ Gamunex-C ☐ Panzyga ☐ Octagam 5% (PI only)

REQUIRED DOCUMENTATION

☐ **Patient Demographics**

☐ **Insurance Card/Information**

☐ **Progress Notes Supporting DX**

☐ **Medication List and H&P**

☐ **Serum Creatinine** *(within last 3 months if treatment naive)*

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

Order is valid for one year unless otherwise noted.

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.

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