IVIG Referral Form

Preferred Clinic (select one): _____

☐ 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) ☐ 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: _____

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

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

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