

# VPRIV® (velaglucerase alfa) Referral Form



**Preferred Clinic** (select one):

## 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 (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 \_\_\_\_\_

## VPRIV ADMINISTRATION

**Dose:** 60 units/kg Other: \_\_\_\_\_  
Every 2 weeks Other: \_\_\_\_\_

## REQUIRED DOCUMENTATION

## 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: \_\_\_\_\_

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

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

<b>Email Referrals To: <a href="mailto:referrals@vivoinfusion.com">referrals@vivoinfusion.com</a> OR Fax Below</b>			<b>Have a Question? Call (720) 902-4111</b>	
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.\*\*

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