

Bevacizumab 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:	Dosing Weight (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.
Infuse via Peripheral IV
Infuse via Implanted Port
Infuse via other vascular access device

Laboratory Orders to be completed by referring office prior to infusion
Name and phone # of who to expect labs from: _____

CBC w/ diff every _____

CMP every _____

Urine Protein every visit (done by Vivo)

Other: _____

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

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: _____

BEVACIZUMAB ADMINISTRATION

Infuse bevacizumab or bevacizumab biosimilar as required by patient's insurance.

Do not use biosimilar (subject to prior authorization).

Dose: _____

Frequency: _____

Call for weight change greater than 10% from order form.

No dose modifications required for weight change.

Flush with 20 ml 0.9% NS post-infusion.

Hold and call provider for urine protein: _____

Other holding criteria:

REQUIRED DOCUMENTATION

Patient Demographics

Insurance Card/Information

Progress Notes Supporting DX

Current Medication List and H&P

CMP and CBC within last 3 months

Baseline Urine Protein (if available)

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

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