

Empliciti® (elotuzumab) 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 Infusion 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: _____

☒ **Clinic Specimen Collection Authorization: If required labs are not received prior to appointment, infusion clinic staff are authorized to draw required labs under the referring provider's NPI and route results back to the referring office.**

- ☐ CBC w/ diff every _____
☐ CMP every _____
☐ OTHER _____

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

PREMEDICATIONS (required)

- ☐ Acetaminophen (Tylenol) 1000 mg 45-90 minutes prior to treatment
☐ Famotidine 20 mg IV 45-90 minutes prior to treatment
☐ Diphenhydramine ☐ 25 mg ☐ 50 mg ☐ PO ☒ IV 45-90 minutes prior to treatment
☐ Dexamethasone 8 mg IV 45-90 minutes prior to treatment
☐ Other:

EMPLICITI ADMINISTRATION

- ☐ Patient is on lenalidomide and dexamethasone
☐ 10 mg/kg IV every week x 2 cycles (28 days), and then every 2 weeks thereafter
☐ 10 mg/kg every 2 weeks
☐ Patient is on pomalidomide and dexamethasone
☐ 10 mg/kg IV every week x two cycles (28 days), then 20 mg/kg IV every 4 weeks thereafter
☐ 20 mg/mg IV every 4 weeks
☐ Patient will take dexamethasone _____ mg orally between 3 and 24 hours prior to infusion
☐ Call for weight change greater than 10% from order form.
☐ No dose modifications required for weight change.

REQUIRED DOCUMENTATION

- ☐ Patient Demographics
☐ Insurance Card/Information
☐ Progress Notes Supporting DX
☐ Current Medication List and H&P
☐ CBC, CMP (within 3 months)

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	