

Poteligeo® (mogamulizumab-kpkc) 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

- ☐ 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: _____

POTELIGEO ADMINISTRATION

- ☐ 1 mg/kg on day 1, 8, 15 and 22 of first 28-day cycle, then on days 1 and 15 of each subsequent cycle
☐ 1 mg/kg on days 1 and 15 of each cycle x _____ 28-day cycles
☐ Call for weight change greater than 10% from referral 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, Thyroid Panel 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	