Bevacizumab Referral Form

Preferred Clinic (select one): _____

VIVO infusion®

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: _____

☑ **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 _____
☑ 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**

Fax Referrals To: 855-314-0443 **Have a Question? Call (720) 902-4111**

Referral is valid for one year unless otherwise noted.

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