Empliciti® (elotuzumab) 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 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**

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

Referral is valid for one year unless otherwise noted.

Revised 11/2026