VIVO infusion

Fax Referrals To: (855) 891-2191
Email Referrals To: referrals@vivoinfusion.comHave a Question? (855) 478-1528

STELARA® (USTEKINUMAB)REFERRAL

(- Required Fields)*

☐ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

☐ New Referral ☐ Referral Renewal ☐ Medication/Treatment Change
☐ Benefits Verification Only ☐ Discontinuation Order

PATIENT INFORMATION

NAME*:	DOB*:	SEX: ☐ M ☐ F
ADDRESS:	PHONE:	
WEIGHT: ☐ LBS ☐ KG HEIGHT:	EMAIL:	
ALLERGIES:		

PHYSICIAN INFORMATION

PHYSICIAN NAME*:	PRACTICE NAME:
ADDRESS:	OFFICE CONTACT*:
PHONE: FAX:	EMAIL *(FOR UPDATES)*:

STELARA Order*:
*(SELECT **ONE** OF THE FOLLOWING)*

ICD-10*: _____

☐ Initial Dosing: Infusion to equal ☐ 260 MG ☐ 390 MG ☐ 520 MG
☐ Dosing: ☐ 45MG ☐ 90MG SQ on week 0, 4, then every 12 weeks
☐ Maintenance Dosing: ☐ 45MG ☐ 90MG SQ every 8 weeks (GI Indication)
☐ Maintenance Dosing: ☐ 45MG ☐ 90MG SQ every 12 weeks

Physician Signature* _____ **Date*(Referral Valid for One Year)** _____

***NPI #** _____

Infusion will be administered per MPP policy and protocols

ICD-10 Description:

***STAT REASON:**
(STAT requests will be assessed per MPP policy and protocols)

Last Infusion/Injection Date: _____

REQUIRED DOCUMENTATION CHECKLIST:

☐ Patient Demographics
☐ Insurance Card/Information
☐ Progress Notes Supporting DX
☐ Current Medication List and H&P
☐ TB Results (w/in 6 months)-*if positive, need negative chest Xray and negative TSpot*

STANDING LAB REQUEST (to be drawn by clinic): ☐ CMP ☐ CBC *Frequency _____

Additional comments/notes:

Locations:

--------Colorado-------
☐ Lakewood

--------Florida---------
☐ Jacksonville
☐ Kissimmee
☐ Port St. Lucie
☐ Suncoast
☐ Winter Park

---------Ohio---------
☐ Beachwood
☐ Middleburg Hts.
☐ Painesville
☐ Youngstown
☐ Westlake
☐ Fairlawn

-------Oklahoma-------
☐ Tulsa

---------Texas---------
☐ Arlington
☐ Cedar Hill
☐ Dallas
☐ Denton
☐ Ft. Worth
☐ Irving
☐ Rockwall
☐ Southlake
☐ Flower Mound
☐ Plano
☐ Tyler

REVISION DATE- 5/2022