



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

UPLIZNA® (inebilizumab-cdon) ORDER FORM
 (* - 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*:
ADDRESS:		SEX: <input type="checkbox"/> M <input type="checkbox"/> F
WEIGHT: LBS KG	HEIGHT:	EMAIL:
ALLERGIES:		
PHYSICIAN INFORMATION		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL (FOR UPDATES):
UPLIZNA Infusion*: <i>(SELECT ONE OF THE FOLLOWING)</i>		ICD-10*:
<p>Initial dose: 300 mg IV infusion followed two weeks later by a second 300mg IV infusion, then 300 mg every 6 months</p> <p>Maintenance Dosing (check only if patient is currently on therapy): 300 mg IV infusion every 6 months</p>		
Physician Signature* _____		Date*(Referral Valid for One Year) _____
*NPI # _____		<i>Infusion will be administered per VIVO policy and protocols</i>
ICD-10 Description: *STAT REASON: (STAT requests will be assessed per VIVO policy and protocols)	REQUIRED DOCUMENTATION CHECKLIST: Patient Demographics Insurance Card/Information Progress Notes supporting DX Current Medication List and H&P Complete Metabolic Panel Hep B Core (if available) Hep B Surface Antigen (within 36 months) TB Results (within 6 months) AQP4 Serum Immunoglobulin	
STANDING LAB REQUEST (to be drawn by clinic): CMP		CBC *Frequency _____
Last Infusion/Injection Date: _____		
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