# VIVO infusion

IVIG REFERRAL

*(* - Required Fields)*

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

☐ **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)*: |

IVIG Infusion*:
*(SELECT **ONE** OF THE FOLLOWING)*

- ☐ Gammagard
- ☐ Octagam
- ☐ Gamunex-C
- ☐ Privigen
- ☐ Bivigam
- ☐ Asceniv

**ICD-10*:** _____
(required & specific as possible)

**Dosing:** _____

**Interval:** _____

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

***NPI #** _____

*Infusion will be administered per VIVO policy and protocols*

## ICD-10 Description:

***STAT REASON:**
(STAT requests will be assessed per VIVO 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
- ☐ Serum Creatinine (within last 3 months if treatment naive)

**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

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