VIVO infusion

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

KEYTRUDA® (pembrolizumab) 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)*:

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

ICD-10*: _____

DOSING:

☐ 200 mg every 3 weeks

OR

☐ 400 mg every 6 weeks

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
☐ CMP (within last 3 months)

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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