vitalcare® INFUSION SERVICES

Pharmacy Name: Vital Care of Meridian
Address: 1501 23rd Avenue
City/State/Zip: Meridian, MS 39301
Phone: 601-482-4003
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Gastroenterology Referral Form

Please attach copy of insurance cards (front and back)

Last Name:	First Name:	DOB:	Practice:
Address:			Address:
City:	State:	Zip: Sex: ○M ○F	City: State: Zip:
Phone:	SSN #:		Prescriber Name:
Insurance Plan			Prescriber NPI:
Insurance Plan:	Insurance Plan:		Nurse/Key Contact:
Policy #:	Policy #:		Phone:
Plan #:	Plan #:		Fax: Email:

Diagnosis and Clinical Information

Please attach clinical/progress notes, labs, test supporting primary diagnosis

☐ Crohn's disease
☐ Ulcerative colitis
☐ Other:

Diagnosis code: _____
Diagnosis code: _____

Currently received and/or prior filed therapies: _____
Length of treatment: _____
Reason for discontinuation: _____

TB/PPD Test: ☐ Positive ☐ Negative Date: _____

Allergies: _____

☐ NKDA

Height: _____ Weight: _____

Site of care: ☐ Home ☐ AIC ☐ Other: _____

Prescription Information

Medication	Dose/Strength	Directions	Refills
☐ Cimzia (certolizumab egol)	☐ 200mg vial (only)	☐ INITIAL: Infuse 400 mg at week 0, 2 and 4, then every 4 weeks thereafter	
☐ Entyvio (vedolizumab)	☐ 300mg vial	☐ INITIAL: Infuse 300mg IV at week 0, 2, 6, then every 8 weeks thereafter ☐ MAINTENTANCE: Infuse 300mg IV every _____ weeks	
☐ Omvoh	☐ 300mg/15mL ☐ 100mg/mL Prefilled syringe ☐ 100mg/mL Prefilled pen	☐ INITIAL: 300mg IV: (3) 300mg induction doses, at week 0, 4 and 8 ☐ MAINTENANCE: Inject 200mg subcutaneously at week 12 and every 4 weeks thereafter	
☐ Remicade (infliximab) ☐ Brand name only ☐ Substitution allowed ☐ Inflectra ☐ Renflexis ☐ Avsola	☐ 100mg vial	☐ INITIAL: Infuse_____ mg/kg IV at week 0, 2, 6, then every 8 weeks thereafter ☐ MAINTENTANCE: Infuse _____ mg/kg IV every _____ weeks ☐ Other _____ ☐ Pharmacist will round to the nearest 100mg ☐ Give exact dose (do NOT round)	
☐ Stelara (ustekinumab)	☐ 130mg / 26mL vial ☐ 90mg (2x 45mg vials)	☐ INITIAL: weight based dosing, infuse IV ☐ 55kg or less: 260mg (2 vials) ☐ 55kg to 85kg 390mg (3 vials) ☐ Greater than 85kg: 520mg (4 vials) ☐ MAINTENTANCE: Inject 90mg SQ 8 weeks after initial dose, then every 8 weeks thereafter	
☐ Skyrizi (risankizumab)	☐ 600mg / 10mL vial (Crohn's disease - infuse over 60 minutes) ☐ 1200mg (2x 600mg vials) ☐ 180mg / 1.2mL (Ulcerative colitis - infuse over 120 minutes) ☐ 360mg / 2.4mL	☐ INITIAL: Infuse 600mg IV at week 0, 4, and 8 ☐ INITIAL: Infuse 1200mg IV at week 0, 4, and 8 ☐ MAINTENANCE: Inject 180mg subcutaneously at week 12 and every 8 weeks thereafter ☐ MAINTENANCE: Inject 360mg subcutaneously at week 12 and every 8 weeks thereafter	
☐ Tremfya	☐ IV Starter Dose: 200mg ☐ 100mg/mL One Press ☐ 100mg/mL Prefilled syringe ☐ 200mg/2mL Prefilled pen ☐ 200mg/mL Prefilled syringe	☐ INITAL: 200mg IV at week 0, 4 and 8 (one-hour infusion) ☐ MAINTENANCE: Inject 100mg subcutaneously at week 16 and every 8 weeks thereafter ☐ MAINTENANCE: Inject 200mg subcutaneously at week 12 and every 4 weeks thereafter	
☐ Other			

Pre-medication and other medications
-Infusion supplies as per protocol
-Anaphylaxis kit as per protocol

☐ Acetaminophen ☐ Diphenhydramine ☐ 250mL 0.9%NaCl for hydration ☐ Other

mg PO prior to infusion
mg ☐ PO ☐ IV

Flush protocol
- NaCl 0.9% 10mL
- Before and after infusion

I authorize Vital Care Infusion Services LLC and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above that I order. I understand that I can revoke this designation at any time by providing written notice to Vital Care.

Physician Signature: _____

Date: _____

PRESCRIBER MUST MANUALLY SIGN. STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED.

The attached document(s) contain confidential information which may be considered to be Protected Health Information and therefore required to be maintained as private and secure under HIPAA. The documents may also contain information which is otherwise considered to be privileged under state and federal laws. This communication is for the intended recipient only. If you are not the intended recipient, or a person responsible for delivering this communication to the intended recipient, you are prohibited from viewing, copying and/or distributing the information contained herein. Unlawful disclosure of the information attached may subject you to monetary penalties and sanctions. If you have received this communication in error, you should notify the sender immediately and thereafter permanently destroy all copies of this document in its entirety.

This form is not considered an order or prescription for medical services and/or supplies unless and until it is formally authorized by a healthcare provider in compliance with applicable laws and regulations.

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