vitalcare of MERIDIAN

Pharmacy Name: Vital Care of Meridian
Address: 1501 23rd Ave
City/State/Zip: Meridian MS 39301

Phone: 601-482-4003
Fax: 601-482-3948
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Rheumatology Referral Form

Please Attach Copy of Insurance Cards (Front & Back)

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

Diagnosis and Clinical Information

Please Attach Clinical/Progress Notes, Labs, Test, Supporting Primary Diagnosis

☐ Rheumatoid Arthritis ☐ Lupus Erythematosus
☐ Ankylosing Spondylitis ☐ Arthritic Psoriasis
☐ Gout
☐ Other: _____
ICD-10: _____

Currently received and/or prior failed therapies: _____

Length of treatment: _____

Reason for discontinuation: _____

TB/PPD Test: ☐ Positive ☐ Negative Date _____
Hep. B ☐ Positive ☐ Negative Date _____
Allergies: _____

☐ NKDA
Height: _____ Weight: _____
Treatment location: ☐ Home ☐ Infusion suite
☐ Other _____

Nursing Orders

☐	Skilled nurse to assess and administer and/or teach self-administration where appropriate. Nurse to provide ongoing support as needed x 1 year.

Prescription Information

Medication	Dose/Strength	Directions
☐ Remicade (infliximab)	☐ 100mg vial	☐ INITIAL: Infuse _____ mg/kg IV over 2-3 hours at week 0, 2, 6 then every 8 weeks thereafter ☐ MAINTENANCE: Infuse _____ mg/kg IV over 2-3 hours every _____ weeks
☐ Stelara (ustekinumab)	☐ 45mg vial	☐ INITIAL: 45mg subcutaneously initially, 4 weeks later, followed by 45mg every 12 weeks ☐ MAINTENANCE: 45mg subcutaneously every 12 weeks ☐ INITIAL: 90mg subcutaneously initially, 4 weeks later, followed by 90mg every 12 weeks ☐ MAINTENANCE: 90mg subcutaneously every 12 weeks
☐ Simponi (golimumab) ARIA	☐ 50mg vial	☐ INITIAL: 2mg/kg IV at weeks 0, 4, and then every 8 weeks ☐ MAINTENANCE: 2mg/kg IV every 8 weeks
☐ Cimzia (certolizumab)	☐ 200mg vial	☐ INITIAL: 400mg subcutaneously at weeks 0, 2, and 4 weeks ☐ MAINTENANCE: 200 mg subcutaneously every 2 weeks ☐ MAINTENANCE: 400 mg subcutaneously every 4 weeks
☐ Cosentyx (secukinumab)	☐ Vial ☐ Prefilled syringe ☐ UnoReady pen	☐ INITIAL: Infuse 6mg/kg IV at week 0 as loading dose ☐ MAINTENANCE: 1.75mg/kg IV every 4 weeks (max maintenance dose 300mg per infusion) ☐ INITIAL: Inject 150mg or 300mg subcutaneously (circle corresponding dose) at weeks 0, 1, 2, 3, and 4. ☐ MAINTENANCE: 150mg or 300mg subcutaneously (circle corresponding dose) every 4 weeks
☐ Orencia (abatacept)	☐ 250mg vial	☐ INITIAL: _____ mg IV Frequency ☐ Every 4 weeks **OR** ☐ 0, 2, 4 weeks and every 4 weeks thereafter
☐ Krystexxa (pegloticase)	☐ 8mg	☐ Infuse 8mg IV over 2 hours every 2 weeks
☐ Tremfya (guselkumab)	☐ 100mg/mL prefilled syringe	☐ INITIAL: 100mg subcutaneously at week 0 and 4 ☐ MAINTENANCE: 100mg subcutaneously every 8 weeks thereafter

Continued on next page.

Prescription Information, continued

Medication	Dose/Strength	Directions
IVIg ☐ Brand _____ ☐ Substitution okay	☐ 0.4gm/kg ☐ 1gm/kg ☐ 2gm/kg ☐ Other: _____	☐ Daily x _____ day(s) ☐ Repeat every _____ week(s) x _____ cycles ☐ Other_____
SCIg ☐ Brand _____ ☐ Substitution okay	☐ _____gram(s) ☐ _____mg per kg ☐ _____grams/kg	☐ Once weekly ☐ Every 2 weeks ☐ Other frequency:_____ ☐ Where clinically appropriate, round to the nearest vial size.
☐ Rituxan (rituximab)	☐ 1000mg ☐ Other: _____	☐ Dose for RA in combination with methotrexate: two 1,000mg intravenous infusions separated by 2 weeks (one course) every 24 weeks - or based on clinical evaluation, but not sooner than every 16 weeks. Methylprednisolone 100mg intravenous or equivalent glucocorticoid is recommended 30 minutes prior to each infusion.
☐ Other		

Pre-Medication and Other Medications
* Infusion supplies as per protocol
* Anaphylaxis kit as per protocol

☐ Acetaminophen _____ mg PO prior to infusion

☐ Diphenhydramine
☐ _____ mg PO or ☐ _____ mL IV prior to infusion

☐ 0.9% NaCl for hydration
_____ mL IV ☐ before ☐ after medication

☐ Other_____

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 which 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