vitalcare® INFUSION SERVICES

Pharmacy Name: Phone:
Address: Fax:
City/State/Zip: Email:

Gastroenterology 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:
Plan I.D. #	Plan I.D. #		Fax: Email:

Diagnosis & 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
☐ Entyvio (vedolizumab)	☐ 300mg vial	☐ INITIAL: Infuse 300mg IV at week 0, 2, 6, then every 8 weeks thereafter ☐ MAINTENANCE: Infuse 300mg IV every _____ weeks	
☐ Inflectra ☐ Remicade ☐ BRAND NAME ONLY ☐ SUBSTITUTION ALLOWED ☐ Renflexis ☐ Avsola	☐ 100mg vial	☐ INITIAL: Infuse_____ mg/kg IV at week 0, 2, 6, then every 8 weeks thereafter ☐ MAINTENANCE: 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: 520 mg (4 vials) ☐ MAINTENANCE: Inject 90mg SC 8 weeks after initial dose, then every 8 weeks thereafter	
☐ Skyrizi (risankizumab)	☐ 600mg / 10mL vial ☐ 180mg / 1.2mL ☐ 360mg / 2.4mL	☐ INITIAL: Infuse 600mg/10mL IV at week 0, 4, and 8 ☐ MAINTENTANCE: 180mg or 360mg by SC injection at week 12, then every 8 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 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