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 Diagnosis code: ____________
☐ Ulcerative Colitis Diagnosis code: ____________
☐ Other: ____________

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 mg PO prior to infusion
☐ Diphenhydramine mg ☐ PO ☐ IV
☐ 250mL 0.9%NaCl for hydration
☐ 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: ____________

Not a valid prescription in Arizona

PRESCRIBER MUST MANUALLY SIGN ‑ STAMP SIGNATURE' SIGNATURE BY OTHER PERSONNEL AND COMPUTER‑GENERATED SIGNATURES WILL NOT BE ACCEPTED

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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.