Vital Care of Atlanta	Phone: 678-705-2055 ext. 1
5881 Glenridge Dr, STE: 110	**Fax: 470-428-2094**
Sandy Springs, GA 30328	**Email: referrals@vitalcareATL.com**

Patient Demographics

****Please send patient demographics, copy of insurance card (front & back), progress notes from the past 1 year with tried & failed therapies supporting primary diagnosis, pertinent labs, & this signed order form****

Last Name: First Name: DOB:
Phone: Sex: ☐ M ☐ F

Provider Name (printed): NPI:
Phone: Fax:
MA/Nurse Contact (print):
email:
Alt. Fax:

Clinical Info (required)

Height (in):
Weight (kg):
ICD 10 Code:
Allergies (required):

Prescription

Stelara

☐ Induction Dose: weight-dosing 130 mg/26 mL vial IV (select one)
- ☐ 55 kg or less: 260 mg (2 vials)
- ☐ 55 kg to 85 kg: 390 mg (3 vials)
- ☐ greater than 85 kg: 520 mg (4 vials)

☐ Maintenance Dose: 45 mg vials x 2 Refills: _____
- ☐ Inject 90 mg SC: select frequency
- ☐ q8weeks (standard)
- ☐ q6weeks (provide clinical notes for failure of complete response to q8weeks)
- ☐ q4 weeks (provide clinical notes for failure of complete response to q6weeks)

Please Fill Out the Following:

Date of TB Test (must be within the last year): _____ Date of Last dose (if maintenance is prescribed) _____

Pre-Meds (optional)

Acetaminophen ___ mg PO 30 mins prior to infusion
Diphenhydramine ___ mg PO or ___ mg IV/IM 30 mins prior to infusion
Solumedrol ___ mg IV Push 30 mins prior to infusion

Anaphylaxis Kit
*mandatory per home infusion policy, will be provided unless otherwise denied by provider

Per pharmacy protocol:
Diphenhydramine 25mg – 50 mg IM x 1 (may repeat x 1) for mild – moderate allergic reaction per judgement of on-site nurse evaluation

Epinephrine 0.3 mg – 0.5 mg IM x 1 (may repeat x 1) for moderate – severe allergic reaction per judgement of on-site nurse evaluation

Flush Order Per Protocol

Peripheral Line: Flush 3-5 mL of NS before & after use PRN

Central Access: Flush 10 mL of NS before & after use PRN
*Heparin is no longer required, if needed, please write in the notes section.

For peripheral lines, RN will place the line prior to the infusion & remove once the infusion is complete. If a patient is getting an infusion over multiple days, RN has the option to leave the line in for no more than 3 days. Should a therapy goes for more than 3 consecutive days, RN will replace the line & remove once the therapy is over for that infusion time

Notes/Other Requests

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 Infusion Services

Physician Signature: _____

Date: _____

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