



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

<b>Patient Demographics</b>
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**\*\*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	<b>Clinical Info (required)</b>
Provider Name (printed): _____ NPI: _____ Phone: _____ Fax: _____ MA/Nurse Contact (print): _____ email: _____ Alt. Fax: _____	Height (in): _____ Weight (kg): _____ ICD 10 Code: _____ Allergies (required): _____

<b>Prescription</b>
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Stelara	<div> <input type="checkbox"/> Induction Dose: weight-dosing 130 mg/26 mL vial IV (select one)           <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span><input type="checkbox"/> 55 kg or less: 260 mg (2 vials)</span> <span><input type="checkbox"/> greater than 85 kg: 520 mg (4 vials)</span> </div> <div style="margin-top: 5px;"> <input type="checkbox"/> 55 kg to 85 kg: 390 mg (3 vials)           </div> </div> <div style="margin-top: 10px;"> <input type="checkbox"/> Maintenance Dose: 45 mg vials x 2           <div style="float: right;">Refills: _____</div> <div style="margin-top: 5px;"> <input type="checkbox"/> Inject 90 mg SC: select frequency           <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span><input type="checkbox"/> q8weeks (standard)</span> <span><input type="checkbox"/> q6weeks (provide clinical notes for failure of complete response to q8weeks)</span> </div> <div> <input type="checkbox"/> q4 weeks (provide clinical notes for failure of complete response to q6weeks)           </div> </div> </div>
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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
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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
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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
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Notes/Other Requests	
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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**

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.