



ATLANTA
vitalcare[®]
INFUSION SERVICES

Vital Care of Atlanta

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Sandy Springs, GA 30328

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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

Clinical Info (required)

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

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

Prescription

Tysabri

300 mg IV over 60 mins q4weeks

Refills: _____

Please Fill Out the Following:

Date of last MRI (please include in progress notes): _____

Date of last dose (if maintenance dose is prescribed): _____

Did you send the patient's TOUCH authorization with the referral paperwork: ____ Yes | ____ No (MANDATORY ENROLLMENT FOR HOME INFUSION - REMS DRUG)

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 Line: 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

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.