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

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