



Pharmacy: Atlanta Vital Care
Address: 5881 Glenridge Dr. NE, STE 110
City/State/Zip: Atlanta, GA, 30328

Phone: 678-705-2055
Fax: 470-428-2094
Email: referrals@vitalcareATL.com

Neurology Referral Form

****Please Attach Copies of insurance cards (Front & Back)****

Last Name: _____ First Name: _____ DOB: _____ Practice: _____
Address: _____ City: _____ State: _____ Zip: _____ Address: _____
Phone: _____ Sex: _____ M _____ F _____ SSN: _____ City: _____ State: _____ Zip: _____

Insurance Information

Insurance Plan: _____ Rx Plan: _____
Policy #: _____ BIN#: _____
Plan ID #: _____ PCN: _____
Group: _____ Rx Group: _____
Prescriber Name: _____
Prescriber NPI: _____
Referral Contact: _____
Phone: _____
Fax: _____
Email: _____

Clinical Information

Height: _____ in Weight: _____ kg Diagnosis (ICD-10 code) _____ Supporting Diagnosis Imaging, studies and/or labs attached (y/n)? _____ Allergies: _____ NKDA

Tried & Failed therapies along w/reasons:

Prescription Information

Drug	Directions	Refills	Drug	Directions	Refills
___ IVIG	Infuse ___ gm/kg IV per day for ___ days every ___ weeks ___ 5% requested (approval is subject to meeting qualifications by payer)		___ Tysabri	**REMS Drug** Infuse 300 mg IV q4w	
___ SCIG	Inject ___ gm/kg SC per day for ___ days every ___ weeks		___ Vyepti	___ Infuse 100 mg IV q12w ___ Infuse 300 mg IV q12w	
___ Ocrevus	___ Induction Dosing: Infuse 300 mg IV at day 1 & day 15 ___ Maintenance Dosing: Infuse 600 mg IV q6mos		___ Vyvgart	Infuse 10 mg/kg IV once a week for ___ weeks with ___ weeks in between cycles ___ 1200 mg for wt > 120 kg	
___ Lequemi	Infuse 10 mg/kg IV q2w *required: baseline MRI, & prior to 5th, 7th, & 14th infusions*		___ Other		
___ Bkerv	**REMS Drug** must complete or update vaccination for meningococcal bacteria (serogroups A, C, W, Y & B) 2 weeks prior to 1st dose gMG (AchR antibody +): ___ Induction Dosing: Infuse 900 mg IV weekly at weeks 0, 1, 2, & 3 ___ Maintenance Dosing (starts 1 week after last 900 mg dose): infuse 1200 mg IV q2weeks				

Pre-medications, Nursing, Anaphylaxis, & Lab Orders

Pre-medications (optional) *will be given 30 mins – 1 hr prior to infusion unless otherwise noted* ___ Acetaminophen 325 mg PO ___ Solumedrol 125 mg IV push ___ Benadryl: ___ 25 mg PO or ___ 25 mg IV ___ NaCl ___ mL IV over 1 hr (highly recommended for minimizing side effects unless fluid restricted in IVIG patients) ___ Other:	Nursing Orders (required) -RN to place & remove PIV for infusion -RN to access central line if needed for infusion -RN to flush line as needed per nursing protocols -RN to administer anaphylaxis medication based on clinical judgement	Anaphylaxis Orders (required) -Diphenhydramine 25 mg – 50 mg IV/IM for mild – moderate ADR -Epinephrine 0.3 mg/0.5 mg IV/IM for moderate -severe ADR, may repeat x 1	Lab Draws (optional) *must be able to draw with lab in a box* Flush Orders (required): 0.9% NS 3-10 mL IV per S.A.S protocol PRN	Notes for Pharmacy:
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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 that I order. I understand that I can revoke this designation at any time by providing written notice to Vital Care.

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.

For medication-specific forms, please visit www.vitalcareATL.com