ATLANTA vitalcare INFUSION SERVICES

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:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone: _____ **Sex:** ___ M F ___ **SSN:** _____

Practice: _____
Address: _____
City: _____ **State:** ___ **Zip:** _____
Prescriber Name: _____
Prescriber NPI: _____
Referral Contact: _____
Phone: _____
Fax: _____
Email: _____

Insurance Information

Insurance Plan: _____ **Rx Plan:** _____
Policy #: _____ **BIN#:** _____
Plan ID #: _____ **PCN:** _____
Group: _____ **Rx Group:** _____

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	
☐ **Lequembi**	Infuse 10 mg/kg IV q2w *required: baseline MRI, & prior to 5th, 7th, & 14th infusions*		☐ **Other**		
☐ **Bkemv**	**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:

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.

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