



Pharmacy: Atlanta Vital Care  
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## 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
___ <b>IVIG</b>	Infuse ___ gm/kg IV per day for ___ days every ___ weeks ___ 5% requested (approval is subject to meeting qualifications by payer)		___ <b>Tysabri</b>	<b>**REMS Drug**</b> Infuse 300 mg IV q4w	
___ <b>SCIG</b>	Inject ___ gm/kg SC per day for ___ days every ___ weeks		___ <b>Vyepti</b>	___ Infuse 100 mg IV q12w ___ Infuse 300 mg IV q12w	
___ <b>Ocrevus</b>	___ Induction Dosing: Infuse 300 mg IV at day 1 & day 15 ___ Maintenance Dosing: Infuse 600 mg IV q6mos		___ <b>Vyvgart</b>	Infuse 10 mg/kg IV once a week for ___ weeks with ___ weeks in between cycles ___ 1200 mg for wt > 120 kg	
___ <b>Leqembi</b>	Infuse 10 mg/kg IV q2w <b>*required: baseline MRI, &amp; prior to 5<sup>th</sup>, 7<sup>th</sup>, &amp; 14<sup>th</sup> infusions*</b>		___ <b>Other</b>		
___ <b>Bkemv</b>	<b>**REMS Drug** must complete or update vaccination for meningococcal bacteria (serogroups A, C, W, Y &amp; B) 2 weeks prior to 1<sup>st</sup> dose</b> 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

<b>Pre-medications (optional)</b> *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:	<b>Nursing Orders (required)</b> -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	<b>Anaphylaxis Orders (required)</b> -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	<b>Lab Draws (optional)</b> *must be able to draw with lab in a box*  <b>Flush Orders (required):</b>  0.9% NS 3-10 mL IV per S.A.S protocol PRN	<b>Notes for Pharmacy:</b>
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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](http://www.vitalcareATL.com)