vitalcare INFUSION SERVICES of ATLANTA

Pharmacy: Vital Care of Atlanta
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

Gastroenterology 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: **Insurance Plan:**
Policy #: **Policy #:**
Plan ID #: **Plan ID:**

Prescription Information

Drug	Directions	Refills	Drug	Directions	Refills
☐ **Remicade** ☐ **Inflectra** ☐ **Other:**	☐ Induction Dosing: Infuse ___ mg/kg IV at week 0, 2, & 6 ☐ Maintenance Dosing: Infuse __ mg/kg every 8 weeks ☐ Alternative Dosing: _____ *Pharmacist will round to nearest vial size unless otherwise noted*		☐ **Cimzia**	☐ Infuse 400 mg IV at week 0, 2, 4, then q4weeks	
☐ **Entyvio**	☐ Induction Dosing (IV): Infuse 300 mg at week 0, 2, & 6 ☐ Maintenance Dosing (IV): infuse 300 mg every 8 weeks ☐ Maintenance Dosing (SC): inject 108 mg every 2 weeks ☐ Alternative Dosing: _____		☐ **Omvoh**	Ulcerative Colitis (UC): ☐ Induction: Infuse 300 mg IV at week 0, 4 & 8 ☐ Maintenance: Inject 200 mg SQ at week 12, and then q4weeks thereafter *Given as 2 consecutive injections of 100 mg each* Crohn's Disease (CD) ☐ Induction: Infuse 900 mg at week 0, 4, & 8 ☐ Maintenance: Inject 300 mg SC at week 12 & then q4weeks *Given as 2 consecutive injections of 100 mg & 200 mg in any order*	
☐ **Stelara**	☐ Induction Dosing (IV): Infuse IV x 1 ☐ 260 mg: ≤ 55 kg | ☐ 390 mg: 55 kg – 85 kg ☐ 520 kg: > 85 kg ☐ Maintenance Dosing (SQ): inject 90 mg q8weeks ☐ Alternative Dosing: _____		☐ **Tremfya**	☐ Induction Dosing: Infuse 200 mg at weeks 0, 4, & 8 ☐ Maintenance Dosing (SC): ☐ Inject 200 mg at week 12 & then q4weeks ☐ Inject 100 mg at week 16 & then q8weeks	
☐ **Skyrizi**	☐ IV Induction Dosing: ☐ Infuse 600 mg IV at week 0, 4, & 8 ☐ Infuse 1200 mg IV at week 0, 4, & 8 ☐ Maintenance Dosing (OBI): ☐ 180 mg SQ at week 12 then q8weeks ☐ 360 mg SQ at week 12 then q8weeks		☐ **Other**		

Pre-medications, Nursing, Anaphylaxis, & Lab Orders

Pre-medications (optional) *will be given 30 mins prior to infusion unless otherwise noted*	Nursing Orders (required)	Anaphylaxis Orders (required)	Lab Draws (optional) *must be able to draw with lab in a box*	Notes for Pharmacy:
☐ Acetaminophen ☐ mg PO ☐ Solumedrol ☐ mg IV push ☐ Benadryl: ☐ mg ☐ PO | ☐ IV ☐ Other:	-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	-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	Flush Orders (required): 0.9% NS 3-10 mL IV per S.A.S protocol PRN	

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

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