

Gastroenterology Referral Form

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

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

Insurance Information

Insurance Plan: _____ **Insurance Plan:** _____ **Prescriber Name:** _____
Policy #: _____ **Policy #:** _____ **Prescriber NPI:** _____
Plan ID #: _____ **Plan ID:** _____ **Referral Contact:** _____
Phone: _____ **Fax:** _____ **Email:** _____

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: _____ <small>*Pharmacist will round to nearest vial size unless otherwise noted*</small>		___ 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: _____		___ Omvo	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 <small>*Given as 2 consecutive injections of 100 mg each*</small> Crohn's Disease (CD) ___ Induction: Infuse 900 mg at week 0, 4, & 8 ___ Maintenance: Inject 300 mg SC at week 12 & then q4weeks <small>*Given as 2 consecutive injections of 100 mg & 200 mg in any order*</small>	
___ 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) <small>*will be given 30 mins prior to infusion unless otherwise noted*</small> ___ Acetaminophen ___ mg PO ___ Solumedrol ___ mg IV push ___ Benadryl: ___ mg ___ PO ___ IV ___ 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) <small>*must be able to draw with lab in a box*</small> 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



Pharmacy: Vital Care of Atlanta

Phone: 678-705-2055

Address: 5881 Glenridge Dr. NE, STE 110

Fax: 470-428-2094

City/State/Zip: Atlanta, GA, 30328

Email: referrals@vitalcareATL.com