

Pharmacy Name: Vital Care of Tampa

Address: 8600 Hidden River Parkway, Ste 300

City/State/Zip: Tampa, FL 33637

Phone: 813-632-8545 Fax: 813-522-8660

Email: referrals@vitalcareoftampa.com

Gastroenterology Referral Form									
Please attach copy of insurance cards (front and back)									
Last Name:	First Name	DOB: Pract		Practice:					
Address:	dress:			Address:					
City:	State:	Zip:	Sex: OMOF	City: State:	Zip:				
Phone:	SSN	N #:		Prescriber Name:					
	Insuran	ce Plan		Prescriber NPI:					
Insurance Plan: Insurance Plan:				Nurse/Key Contact:					
Policy #: Policy #:				Phone:					
Plan #:	Plar	า #:		Fax: Email:					
Diagnosis and Clinical Information									
Crohn's diseas Ulcerative col Other: Currently received	se Diagnosis	ttach clinical/progress notes, labs, test supporting primary diagnosis code: TB/PPD Test: Positive Negative Date: code: Allergies:							
Length of treatment:			NKDA						
Reason for discontinuation: Height:									
Reason for discon-	unuation		Site of care: Home	AIC Other:					
		Prescription	Information						
Medication	Dose/Strength		Direction	s	Refills				
Cimzia (certolizumab egol)	200mg vial (only)	☐ INITIAL: Infuse 400 mg at week 0, 2 and 4, then every 4 weeks thereafter							
Entyvio (vedolizumab)	300mg vial	☐ INITIAL: Infuse 300mg IV at week 0, 2, 6, then every 8 weeks thereafter ☐ MAINTENANCE: Infuse 300mg IV every weeks							
☐ Omvoh	300mg/15mL 100mg/mL prefilled syringe 100mg/mL prefilled pen 200mg/mL prefilled syringe (only for Crohn's disease, maintenance) 200mg/mL prefilled pen (only for Crohn's disease, maintenance)	For use with ulcerative colitis INITIAL: Week 0, 4, 8: Infuse 300mg IV over at least 30 minutes MAINTENANCE: Week 12 and every 4 weeks thereafter: Inject 200mg SC (given as two consecutive injections of 100 mg each) For use with Crohn's disease INITIAL: Week 0, 4, 8: Infuse 900mg IV over at least 90 minutes MAINTENANCE: Week 12 and every 4 weeks thereafter: Inject 300mg SC (given as two consecutive injections of 100mg and 200mg, in any order)							
Remicade (infliximab) Brand name only Substitution allowed Inflectra Renflexis Avsola	☐ 100mg vial	☐ INITIAL: Infuse mg/kg IV at week 0, 2, 6, then every 8 weeks thereafter ☐ MAINTENANCE: Infuse mg/kg IV every weeks ☐ Other ☐ Pharmacist will round to the nearest 100mg ☐ Give exact dose (do NOT round)							
Stelara (ustekinumab)	☐ 130mg / 26mL vial ☐ 90mg (2x 45mg vials)	☐ INITIAL: weight based dosing, infuse IV ☐ 55kg or less: 260mg (2 vials) ☐ Greater than 85kg: 520mg (4 vials) ☐ MAINTENANCE: Inject 90mg SQ 8 weeks after initial dose, then every 8 weeks thereafter							
Skyrizi (risankizumab)	600mg / 10mL vial Crohn's disease - infuse over 60 minutes 1200mg (2x 600mg vials) Ulcerative colitis - infuse over 120 minutes 180mg / 1.2mL 360mg / 2.4mL	☐ INITIAL: Infuse 600mg IV at week 0, 4, and 8 ☐ INITIAL: Infuse 1200mg IV at week 0, 4, and 8 ☐ MAINTENANCE: Inject 180mg subcutaneously at week 12 and every 8 weeks thereafter ☐ MAINTENANCE: Inject 360mg subcutaneously at week 12 and every 8 weeks thereafter							
☐ Tremfya	□ IV Starter Dose: 200mg □ 100mg/mL One Press □ 100mg/mL prefilled syringe □ 200mg/2mL prefilled pen □ 200mg/mL prefilled syringe	☐ INITIAL: 200mg IV at week 0, 4 and 8 (one-hour infusion) ☐ MAINTENANCE: Inject 100mg subcutaneously at week 16 and every 8 weeks thereafter ☐ MAINTENANCE: Inject 200mg subcutaneously at week 12 and every 4 weeks thereafter							
Other									

Prescription Information - Continued								
Pre-medication and other medications - Infusion supplies as per protocol - Anaphylaxis kit as per protocol	☐ Acetaminophen☐ Diphenhydramine☐ 250mL 0.9%NaCl for hydration☐ Other	mg PO prior to infusion mg PO IV	Flush protocol - NaCl 0.9% 10mL - Before and after infusion					

PRESCRIBER MUST MANUALLY SIGN. STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED.

Physician Signature:

Date:

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.

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

Iorder, Iunderstand that I can revoke this designation at any time by providing written notice to Vital Care.