vitalcare® INFUSION SERVICES

Pharmacy Name: Vital Care of Tampa
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Gastroenterology Referral Form

Please attach copy of insurance cards (front and back)

Last Name:	First Name:	DOB:	Practice:		
Address:			Address:		
City:	State:	Zip: Sex: ○M ○F	City:	State:	Zip:
Phone:	SSN #:		Prescriber Name:		
Insurance Plan			Prescriber NPI:		
Insurance Plan:	Insurance Plan:		Nurse/Key Contact:		
Policy #:	Policy #:		Phone:		
Plan #:	Plan #:		Fax:	Email:	

Diagnosis and Clinical Information

Please attach clinical/progress notes, labs, test supporting primary diagnosis

☐ Crohn's disease
☐ Ulcerative colitis
☐ Other:

Diagnosis code: _____
Diagnosis code: _____

Currently received and/or prior filed therapies: _____
Length of treatment: _____
Reason for discontinuation: _____

TB/PPD Test: ☐ Positive ☐ Negative Date: _____
Allergies: _____
☐ NKDA
Height: _____ Weight: _____
Site of care: ☐ Home ☐ AIC ☐ Other: _____

Prescription Information

Medication	Dose/Strength	Directions	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) ☐ 55kg to 85kg 390mg (3 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			

Continued on next page.

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

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.