

Gastroenterology Referral Form

Please attach copy of insurance cards (front and back)

Last Name:		First Name:		DOB:	Practice:
Address:					
City:	State:	Zip:	Sex: <input type="radio"/> M <input type="radio"/> F	City:	State: Zip:
Phone:	SSN #:		Prescriber Name:		
Insurance Plan					
Insurance Plan:		Insurance Plan:		Prescriber NPI:	
Policy #:		Policy #:		Nurse/Key Contact:	
Plan #:		Plan #:		Fax:	Email:

Diagnosis and Clinical Information

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

Crohn's disease Diagnosis code: _____ TB/PPD Test: Positive Negative Date: _____

Ulcerative colitis Diagnosis code: _____ Allergies: _____

Other: _____

Currently received and/or prior filed therapies: _____

Length of treatment: _____

Reason for discontinuation: _____

NKDA

Height: _____ Weight: _____

Site of care: Home AIC Other: _____

Prescription Information

Medication	Dose/Strength	Directions	Refills
<input type="checkbox"/> Cimzia (certolizumab egol)	<input type="checkbox"/> 200mg vial (only)	<input type="checkbox"/> INITIAL: Infuse 400 mg at week 0, 2 and 4, then every 4 weeks thereafter	
<input type="checkbox"/> Entyvio (vedolizumab)	<input type="checkbox"/> 300mg vial	<input type="checkbox"/> INITIAL: Infuse 300mg IV at week 0, 2, 6, then every 8 weeks thereafter <input type="checkbox"/> MAINTENANCE: Infuse 300mg IV every _____ weeks	
<input type="checkbox"/> Omvoh	<input type="checkbox"/> 300mg/15mL <input type="checkbox"/> 100mg/mL prefilled syringe <input type="checkbox"/> 100mg/mL prefilled pen <input type="checkbox"/> 200mg/mL prefilled syringe (only for Crohn's disease, maintenance) <input type="checkbox"/> 200mg/mL prefilled pen (only for Crohn's disease, maintenance)	For use with ulcerative colitis <input type="checkbox"/> INITIAL: Week 0, 4, 8: Infuse 300mg IV over at least 30 minutes <input type="checkbox"/> 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 <input type="checkbox"/> INITIAL: Week 0, 4, 8: Infuse 900mg IV over at least 90 minutes <input type="checkbox"/> MAINTENANCE: Week 12 and every 4 weeks thereafter: Inject 300mg SC (given as two consecutive injections of 100mg and 200mg, in any order)	
<input type="checkbox"/> Remicade (infliximab) <input type="checkbox"/> Brand name only <input type="checkbox"/> Substitution allowed <input type="checkbox"/> Inflectra <input type="checkbox"/> Renflexis <input type="checkbox"/> Avsola	<input type="checkbox"/> 100mg vial	<input type="checkbox"/> INITIAL: Infuse _____ mg/kg IV at week 0, 2, 6, then every 8 weeks thereafter <input type="checkbox"/> MAINTENANCE: Infuse _____ mg/kg IV every _____ weeks <input type="checkbox"/> Other _____ <input type="checkbox"/> Pharmacist will round to the nearest 100mg <input type="checkbox"/> Give exact dose (do NOT round)	
<input type="checkbox"/> Stelara (ustekinumab)	<input type="checkbox"/> 130mg / 26mL vial <input type="checkbox"/> 90mg (2x 45mg vials)	<input type="checkbox"/> INITIAL: weight based dosing, infuse IV <input type="checkbox"/> 55kg or less: 260mg (2 vials) <input type="checkbox"/> 55kg to 85kg 390mg (3 vials) <input type="checkbox"/> Greater than 85kg: 520mg (4 vials) <input type="checkbox"/> MAINTENANCE: Inject 90mg SQ 8 weeks after initial dose, then every 8 weeks thereafter	
<input type="checkbox"/> Skyrizi (risankizumab)	<input type="checkbox"/> 600mg / 10mL vial Crohn's disease - infuse over 60 minutes <input type="checkbox"/> 1200mg (2x 600mg vials) Ulcerative colitis - infuse over 120 minutes <input type="checkbox"/> 180mg / 1.2mL <input type="checkbox"/> 360mg / 2.4mL	<input type="checkbox"/> INITIAL: Infuse 600mg IV at week 0, 4, and 8 <input type="checkbox"/> INITIAL: Infuse 1200mg IV at week 0, 4, and 8 <input type="checkbox"/> MAINTENANCE: Inject 180mg subcutaneously at week 12 and every 8 weeks thereafter <input type="checkbox"/> MAINTENANCE: Inject 360mg subcutaneously at week 12 and every 8 weeks thereafter	
<input type="checkbox"/> Tremfya	<input type="checkbox"/> IV Starter Dose: 200mg <input type="checkbox"/> 100mg/mL One Press <input type="checkbox"/> 100mg/mL prefilled syringe <input type="checkbox"/> 200mg/2mL prefilled pen <input type="checkbox"/> 200mg/mL prefilled syringe	<input type="checkbox"/> INITIAL: 200mg IV at week 0, 4 and 8 (one-hour infusion) <input type="checkbox"/> MAINTENANCE: Inject 100mg subcutaneously at week 16 and every 8 weeks thereafter <input type="checkbox"/> MAINTENANCE: Inject 200mg subcutaneously at week 12 and every 4 weeks thereafter	
<input type="checkbox"/> 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

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.