vitalcare® INFUSION SERVICES

Pharmacy Name: Phone:
Address: Fax:
City/State/Zip: Email:

Rheumatology Referral Form

Please Attach Copy of Insurance Cards (Front & Back)

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

Diagnosis and Clinical Information

Please Attach Clinical/Progress Notes, Labs, Test, Supporting Primary Diagnosis

☐ Rheumatoid Arthritis
☐ Ankylosing Spondylitis
☐ Gout
☐ Other: _____
ICD-10: _____

☐ Lupus Erythematosus
☐ Arthritic Psoriasis

Currently received and/or prior filed therapies: _____

Length of Treatment: _____
Reason for Discontinuation: _____

TB/PPD Test: ☐ Positive ☐ Negative Date _____
Hep. B ☐ Positive ☐ Negative Date _____
Allergies: _____

☐ NKDA

Height _____ Weight _____

Site of Care: ☐ Home ☐ AIC ☐ Other _____

Prescription Information

Medication	Dose/Strength	Directions
☐ Remicade (infliximab)	☐ 100mg vial	☐ INITIAL: Infuse _____ mg/kg IV over 2-3 hours at week 0, 2, 6 then every 8 weeks thereafter ☐ MAINTENANCE: Infuse _____ mg/kg IV over 2-3 hours every ____ weeks
☐ Stelara (ustekinumab)	☐ 45mg vial	☐ INITIAL: 45mg SUBQ initially, 4 weeks later, followed by 45mg every 12 weeks ☐ MAINTENANCE: 45mg SUBQ every 12 weeks ☐ INITIAL: 90mg SUBQ initially, 4 weeks later, followed by 90mg every 12 weeks ☐ MAINTENANCE: 90mg SUBQ every 12 weeks
☐ Simponi (golimumab) ARIA	☐ 50mg vial	☐ INITIAL: 2mg/kg IV at weeks 0, 4, and then every 8 weeks ☐ MAINTENANCE: 2mg/kg IV every 8 weeks
☐ Cimzia (certolizumab)	☐ 200mg vial	☐ INITIAL: 400mg SUBQ at weeks 0, 2, and 4 weeks ☐ MAINTENANCE: 200 mg SUBQ every 2 weeks ☐ MAINTENANCE: 400 mg SUBQ every 4 weeks
☐ Orencia (abatacept)	☐ 250mg vial	☐ INITIAL: _____ mg IV Frequency ☐ Every 4 weeks **OR** ☐ 0, 2, 4 weeks and every 4 weeks thereafter
☐ Kystexxa (pegloticase)	☐ 8mg	Infuse 8mg IV over 2 hours every 2 weeks

Pre-Medication & Other Medications
* Infusion supplies as per protocol
* Anaphylaxis Kit as per protocol

☐ Acetaminophen mg PO prior to infusion
☐ Diphenhydramine mg ☐ PO ☐ IV
☐ Methylprednisolone_____mg IV over _____ min.
☐ Other

Flush Protocol
* NaCl 0.9% 10ml
* Before & 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 which 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