Pharmacy Name:_____ Phone:_____

Address:_____ Fax:_____

City/State/Zip:_____ Email:_____

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 Information

Insurance Plan:	Insurance Plan:	Prescriber NPI:
Policy #	Policy #	Nurse/Key Contact:
Plan I.D. #	Plan I.D. #	Phone: Fax:
		Email:

Diagnosis and Clinical Information

Please attach clinical/progress notes and test results supporting primary diagnosis

☐ Crohn's disease ☐ Lupus Erythematosus

☐ Ulcerative colitis ☐ Arthritic Psoriasis

☐ Other: _____

_____

Currently received and/or prior failed therapies: _____

Length of treatment: _____

Reason for discontinuation: _____

TB/PPD Test: ☐ Positive ☐ Negative Date _____

Allergies: _____

_____

_____

☐ NKDA

Height: _____ Weight: _____

Treatment location: ☐ Home ☐ Infusion suite

☐ Other: _____

Labs

Test	Frequency

Nursing Orders

☐	Skilled nurse to assess and administer and/or teach self-administration where appropriate. Nurse to provide ongoing support as needed x 1 year.

Prescription Information

Medication	Dose/Strength	Directions	Refills
☐ Cimzia (certolizumab egol)	☐ 200mg vial (only)	☐ INITIAL: Infuse 400mg subcutaneously at week 0, 2 and 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 subcutaneously (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 subcutaneously (given as two consecutive injections of 100mg and 200mg, in any order)	

Continued on next page.

Prescription Information, continued

Medication	Dose/Strength	Directions	Refills
☐ 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 (one time) ☐ 55kg or less: 260mg (2 vials) ☐ 55kg to 85kg 390mg (3 vials) ☐ Greater than 85kg: 520mg (4 vials) ☐ MAINTENANCE: Inject 90mg subcutaneously 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) ☐ INITIAL: 400mg subcutaneously at week 0, 4, and 8 (given as two consecutive injections of 200mg each) ☐ 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			

Pre-Medication and Other Medications
* Infusion supplies as per protocol
* Anaphylaxis kit as per protocol

☐ Acetaminophen _____ mg PO prior to infusion

☐ Diphenhydramine
☐ _____ mg PO or ☐ _____ mL IV prior to infusion

☐ 0.9% NaCl for hydration
_____ mL IV ☐ before ☐ after medication

☐ Other_____

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 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