vitalcare
INFUSION SERVICES
of GREENVILLE

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

Rheumatology Referral Form

PATIENT **PLEASE ATTACH 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

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

Diagnosis and Clinical

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

☐ Rheumatoid Arthritis
☐ Ankylosing Spondylitis
☐ Gout
☐ ICD-10 ____________________

Lupus Erythematosus
Arthritic Psoriasis
Other: ____________________

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: ____________________

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____

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
Krystexxa (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

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