Vital Care of Greenville
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vitalcare® INFUSION SERVICES of GREENVILLE

LOCAL

GASTRO REFERRAL

----Patient Info----

Name:	Street Address:	
DOB:	City/State/ZIP:	
Primary Phone #:	Email:	
Alternate Phone #:	Height(inches):	Weight: [Specify Lbs/Kgs]
Insurance (primary and secondary)		
Insured Name:	Please send:	
Insured DOB:	-Insurance Card(s) -Medical Records -Previous Therapies -Pertinent Labs	

----Prescription----

DRUG	Dose	Directions
☐ Entyvio	300 mg	Infuse 300 mg at week 0, 2, 6 and every 8 weeks thereafter
☐ Infliximab Inflectra Remicade Avsola Renflexis	100 mg	☐ Infuse _____ mg/kg at week 0, 2, 6 and every 8 weeks thereafter ☐ Other Directions (specify below)

DRUG	Dose	Directions
☐ Stelara (Initial)	260-520 mg (IV)	Infuse one time dose based on weight (per mfg guide)
☐ Stelara (Maint)	90 mg (INJ) (2) 45 mg vials	Inject 90 mg with nurse support every 8 weeks
☐ Skyrizi (Initial)	600 mg (IV)	Infuse IV dose at week 0, 4 and 8
☐ Skyrizi (Maint)	360 mg (INJ)	Inject 360 mg at week 12 and every 8 weeks thereafter

Other Drug or Alterntive Dosing of Above Therapies

☐ _____ _____ _____

Site of care: ☐ Private Suite ☐ Home

Pre-Meds: _____

----Clinical----

Diagnosis: ICD-10 Code: Notes:

Allergies: IV Access: ☐ PIV by nurse ☐ PIC Line In Place

Lab Orders:	Frequency
☐ CBC w/ Diff	_____
☐ CMP	_____
☐ CRP	_____
☐ ESR	
☐ Other	
_____	_____
_____	_____

Prescriber Information

Name: _____ NPI: _____

Practice: _____

Address: _____

City/State/ZIP: _____

Phone: _____ Fax: _____

Nurse/Contact Name: _____

I authorize Vital Care Infusion Services LLC and it's 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 or electronic notice to Vital Care.

Physician Signature: _____

Date: _____

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED