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:

Insured DOB:

Please send:
-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)	______ 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)	______ 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

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