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vitalcare® INFUSION SERVICES of GREENVILLE

LOCAL

# RHEUMATOLOGY 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<br>-Previous Therapies -Pertinent Labs | |

## ----Prescription----

| DRUG | Dose | Directions |
|---|---|---|
| ☐ Krystexxa | 8 mg | Infuse 8 mg IV every 2 weeks |
| ☐ Infliximab<br>Inflectra<br>Remicade<br>Avsola<br>Renflexis | 100 mg vial | ☐ Infuse _____ mg/kg at week 0, 2, 6 and every 8 weeks thereafter<br>☐ 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 |
| ☐ Simponi Aria (Initial) (golimumab)<br>☐ Simponi Aria (Maint) (golimumab) | 50 mg vial | Infuse 2 mg/kg at week 0, 4 & 8<br>Infuse 2 mg/kg every 8 weeks |

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**