

----Patient Info----

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

----Prescription----

IV Immunoglobulin <u>Load Dose</u> 0.4 gm/kg 1 gm/kg 2 gm/kg _____ gm Frequency: _____ <u>Maint Dose</u> 0.4 gm/kg 1 gm/kg 2 gm/kg _____ gm Frequency: _____		Other Specialty Medication Drug: _____ Insurance preferred biosimilars not allowed <u>Dose/Frequency/Instructions:</u> Site of care: Private Suite Home	
Pre-Meds: Acetaminophen Diphenhydramine Hydration Other			
Specify Dose: _____			

----Clinical----

Diagnosis:		ICD-10 Code:	Notes:
Allergies:			IV Access: PIV Port
<u>Lab Orders:</u> CBC/Diff _____ CMP _____ IgG w/Subclass 1-4 _____ Quant. IG _____ Other _____ _____ _____		<u>Prescriber Information</u> 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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