

----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:		<u>Please send:</u>	
Insured DOB:		-Insurance Card(s) -Medical Records -Previous Therapies -Pertinent Labs	

----Prescription----

DRUG	Dose	Directions	DRUG	Dose	Directions
Tremfya	Induction	Infuse 200 mg at week 0, 4, 8	Stelara (Initial)	_____ mg (IV)	Infuse one time dose based on weight (per mfg guide)
	Maint	Inject _____ mg every ___ weeks	Stelara (Maint)	90 mg (INJ) (2) 45 mg vials	Inject 90 mg with nurse support every 8 weeks
Infliximab	100 mg	Infuse _____ mg/kg at week 0, 2, 6 and every 8 weeks thereafter	Skyrizi (Initial)	_____ mg (IV)	Infuse IV dose at week 0, 4 and 8
Inflectra			Skyrizi (Maint)	360 mg (INJ)	Inject 360 mg at week 12 and every 8 weeks thereafter
Remicade			Other Drug or Alternative Dosing of Above Therapies		
Avsola					
Renflexis		Other: _____			
Entyvio	300 mg	Infuse 300 mg at week 0, 2, 6 and every 8 weeks thereafter			
Site of care:		Private Suite	Home		
Pre-Meds: _____					

----Clinical----

Diagnosis:	ICD-10 Code:	Notes:
Allergies:	IV Access:	PIV by nurse PIC Line In Place
<u>Lab Orders:</u>	<u>Frequency</u>	<u>Prescriber Information</u>
CBC w/ Diff	_____	Name: _____ NPI: _____
CMP	_____	Practice: _____
CRP	_____	Address: _____
ESR	_____	City/State/ZIP: _____
Other	_____	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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