



**GREENVILLE
& SPARTANBURG**



RHEUMATOLOGY

P: 864.438.2800 FAX: 864.438.2801

RHEUMATOLOGY

-----PATIENT DEMOGRAPHICS-----

| | | | |
|-----------------------------------|--|--|--|
| 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) -Medical Records -Previous Therapies -Pertinent Labs | |

-----ORDERS-----

*Anaphylaxis and Flush orders per pharmacy protocol

| <u>DRUG</u> | <u>Dose & Directions</u> | <u>DRUG</u> | <u>Dose & Directions</u> |
|--|---|--|--|
| IVIG | Infuse _____ gm/kg every _____ weeks Other Dosing: _____ | Krystexxa | Infuse 8 mg IV every 2 weeks |
| INFLIXIMAB | Infuse _____ mg/kg every _____ weeks Plan Preference of: Remicade, Inflectra Avsola, Renflexis | Simponi Aria (golimumab) | 2 mg/kg New Start: Infuse week 0, 4 & Q8 wks thereafter Maint: Infuse every 8 wks |
| Site of care: Private Suite Home | | Other Drug or Alternative Dosing of Above Therapies | |
| Pre-Meds: _____ | | | |

-----CLINICAL-----

| | | | |
|--------------------|------------------|-------------------------------|-------------------------------------|
| Diagnosis: | | ICD-10 Code: | Notes: |
| Allergies: | | IV Access: | PIV by nurse PIC/PORT In Place |
| <u>Lab Orders:</u> | <u>Frequency</u> | Prescriber Information | |
| 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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