

Gastroenterology Referral Form

****Please Attach Copy of Insurance Cards (Front & Back)****

Last Name:	First Name:	DOB:	Practice:
Address:			Address:
City:	State:	Zip:	Sex: <input type="radio"/> M <input type="radio"/> F
Phone:	SSN#		City: State: Zip:

Insurance Information

Insurance Plan:	Insurance Plan:	Prescriber Name:
Policy #	Policy #	Prescriber NPI:
Plan I.D. #	Plan I.D. #	Nurse/Key Contact:
		Phone:
		Fax: Email:

Diagnosis & Clinical Information

****Please Attach Clinical/Progress Notes, Labs, Test, Supporting Primary Diagnosis****

<input type="checkbox"/> Crohn's Disease	Diagnosis code: _____	TB/PPD Test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Date: _____
<input type="checkbox"/> Ulcerative Colitis	Diagnosis code: _____	Allergies: _____	
<input type="checkbox"/> Other: _____	_____		
Currently received and/or prior filed therapies: _____		<input type="checkbox"/> NKDA	
Length of treatment: _____		Height: _____ Weight: _____	
Reason for discontinuation: _____		Site of Care: <input type="checkbox"/> Home <input type="checkbox"/> AIC <input type="checkbox"/> Other: _____	

Prescription Information

Medication	Dose/Strength	Directions	Refills
<input type="checkbox"/> Entyvio (vedolizumab)	<input type="checkbox"/> 300mg vial	<input type="checkbox"/> INITIAL: Infuse 300mg IV at week 0, 2, 6, then every 8 weeks thereafter <input type="checkbox"/> MAINTENANCE: Infuse 300mg IV every _____ weeks	
<input type="checkbox"/> Inflectra (infliximab) <input type="checkbox"/> Remicade <input type="checkbox"/> Renflexis	<input type="checkbox"/> 100mg vial	<input type="checkbox"/> INITIAL: Infuse _____ mg/kg IV at week 0, 2, 6, then every 8 weeks thereafter <input type="checkbox"/> MAINTENANCE: Infuse _____ mg/kg IV every _____ weeks <input type="checkbox"/> Other _____ <input type="checkbox"/> Pharmacist will round to the nearest 100mg <input type="checkbox"/> Give exact dose (do NOT round)	
<input type="checkbox"/> Stelara (ustekinumab)	<input type="checkbox"/> 130 mg / 26ml vial <input type="checkbox"/> 90mg (2x 45mg vials)	<input type="checkbox"/> INITIAL: Weight based dosing, infuse IV <input type="checkbox"/> 55kg or less: 260mg (2 vials) <input type="checkbox"/> 55kg to 85kg: 390mg (3 vials) <input type="checkbox"/> Greater than 85kg: 520 mg (4 vials) <input type="checkbox"/> MAINTENANCE: Inject 90mg SQ 8 weeks after initial dose, then every 8 weeks thereafter	
<input type="checkbox"/> Skyrizi (risankizumab)	<input type="checkbox"/> 600mg / 10 ml vial	<input type="checkbox"/> INITIAL: Infuse 600mg/10mL IV at week 0, 4, and 8 <input type="checkbox"/> MAINTENANCE: Inject 360mg/2.4ml SQ via injector at week 12, then every 8 weeks thereafter	

Pre-medication & other medications

- * Infusion supplies as per protocol
- * Anaphylaxis kit as per protocol

<input type="checkbox"/> Acetaminophen	mg PO prior to infusion
<input type="checkbox"/> Diphenhydramine	mg <input type="checkbox"/> PO <input type="checkbox"/> IV
<input type="checkbox"/> 250ml 0.9%NaCl for hydration	
<input type="checkbox"/> Other	

Flush Protocol

- * NaCl 0.9% 10ml
- * Before & after infusion

I authorize Vital Care Infusion Services LLC and its 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 notice to Vital Care.

Physician Signature: _____

Date: _____

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

The attached document(s) contain confidential information which may be considered to be Protected Health Information and therefore required to be maintained as private and secure under HIPAA. The documents may also contain information which is otherwise considered to be privileged under state and federal laws. This communication is for the intended recipient only. If you are not the intended recipient, or a person responsible for delivering this communication to the intended recipient, you are prohibited from viewing, copying and/or distributing the information contained herein. Unlawful disclosure of the information attached may subject you to monetary penalties and sanctions. If you have received this communication in error, you should notify the sender immediately and thereafter permanently destroy all copies of this document in its entirety.

This form is not considered an order or prescription for medical services and/or supplies unless and until it is formally authorized by a healthcare provider in compliance with applicable laws and regulations.