vitalcare® INFUSION SERVICES

Pharmacy Name:_____ Phone:_____
Address:_____ Fax:_____
City/State/Zip:_____ Email:_____

Rheumatology Referral Form

Please Attach Copy of Insurance Cards (Front & Back)

Last Name:	First Name:	DOB:	Practice:	
Address:			Address:	
City:	State:	Zip: Sex: ☐ M ☐ F	City:	State: Zip:
Phone:	SSN:		Prescriber Name:	
Insurance Information			Prescriber NPI:	
Insurance Plan:	Insurance Plan:		Nurse/Key Contact:	
Policy #	Policy #		Phone:	Fax:
Plan I.D. #	Plan I.D. #		Email:	

Diagnosis and Clinical Information

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

☐ Rheumatoid Arthritis ☐ Lupus Erythematosus
☐ Ankylosing Spondylitis ☐ Arthritic Psoriasis
☐ Gout
☐ Other: _____
ICD-10: _____

Currently received and/or prior failed therapies:_____
_____
Length of treatment: _____
Reason for discontinuation: _____

TB/PPD Test: ☐ Positive ☐ Negative Date _____
Hep. B ☐ Positive ☐ Negative Date _____
Allergies: _____
_____
_____
☐ NKDA
Height: _____ Weight: _____
Site of Care: ☐ Home ☐ AIC ☐ Other: _____

Prescription Information

Medication	Dose/Strength	Directions
☐ Remicade (infliximab)	☐ 100mg vial	☐ INITIAL: Infuse _____ mg/kg IV over 2-3 hours at week 0, 2, 6 then every 8 weeks thereafter ☐ MAINTENANCE: Infuse _____ mg/kg IV over 2-3 hours every _____ weeks
☐ Stelara (ustekinumab)	☐ 45mg vial	☐ INITIAL: 45mg SC initially, 4 weeks later, followed by 45mg every 12 weeks ☐ MAINTENANCE: 45mg SC every 12 weeks ☐ INITIAL: 90mg SC initially, 4 weeks later, followed by 90mg every 12 weeks ☐ MAINTENANCE: 90mg SC every 12 weeks
☐ Simponi (golimumab) ARIA	☐ 50mg vial	☐ INITIAL: 2mg/kg IV at weeks 0, 4, and then every 8 weeks ☐ MAINTENANCE: 2mg/kg IV every 8 weeks
☐ Cimzia (certolizumab)	☐ 200mg vial	☐ INITIAL: 400mg SC at weeks 0, 2, and 4 weeks ☐ MAINTENANCE: 200 mg SC every 2 weeks ☐ MAINTENANCE: 400 mg SC every 4 weeks
☐ Cosentyx (secukinumab)	☐ Vial ☐ Prefilled syringe ☐ UnoReady pen	☐ INITIAL: Infuse 6mg/kg IV at week 0 as loading dose ☐ MAINTENANCE: 1.75mg/kg IV every 4 weeks (max maintenance dose 300mg per infusion) ☐ INITIAL: Inject 150mg or 300mg SUBQ (circle corresponding dose) at Weeks 0, 1, 2, 3, and 4. ☐ MAINTENANCE: 150mg or 300mg SUBQ (circle corresponding dose) every 4 weeks
☐ Orencia (abatacept)	☐ 250mg vial	☐ INITIAL: _____ mg IV Frequency ☐ Every 4 weeks **OR** ☐ 0, 2, 4 weeks and every 4 weeks thereafter
☐ Krystexxa (pegloticase)	☐ 8mg	☐ Infuse 8mg IV over 2 hours every 2 weeks
☐ Tremfya (guselkumab)	☐ 100mg/mL prefilled syringe	☐ INITIAL: 100mg SC at week 0 and 4 ☐ MAINTENANCE: 100mg SC every 8 weeks thereafter
IVIg ☐ Brand _____ ☐ Substitution okay	☐ 0.4gm/kg ☐ 1gm/kg ☐ 2gm/kg ☐ Other: _____	☐ Daily x _____ day(s) ☐ Repeat every _____ week(s) x _____ cycles ☐ Other_____

Continued on next page.

Prescription Information - Continued

Medication	Dose/Strength	Directions
SCIg ☐ Brand _____ ☐ Substitution okay	☐ _____gram(s) ☐ _____mg per kg ☐ _____grams/kg	☐ Once weekly ☐ Every 2 weeks ☐ Other frequency:_____ ☐ Where clinically appropriate, round to the nearest vial size.
☐ Rituxan (rituximab)	☐ 1000mg ☐ Other: _____	☐ Dose for RA in combination with methotrexate: two 1,000mg intravenous infusions separated by 2 weeks (one course) every 24 weeks - or based on clinical evaluation, but not sooner than every 16 weeks. Methylprednisolone 100mg intravenous or equivalent glucocorticoid is recommended 30 minutes prior to each infusion.
Remicade (infliximab) ☐ Brand _____ ☐ Substitution okay	☐ _____ mg/kg	☐ INITIAL: 3mg/kg IV given at 0, 2 and 6 weeks as an induction regimen ☐ MAINTENANCE: 3mg/kg IV given every 8 weeks thereafter as a maintenance regimen. REMICADE or Infliximab should be given in combination with methotrexate. For adult patients who have an incomplete response, consider adjusting the dose up to 10mg/kg, or treating as often as every 4 weeks, bearing in mind that risk of serious infections is increased at higher doses.
☐ Other		

Pre-Medication and Other Medications
* Infusion supplies as per protocol
* Anaphylaxis Kit as per protocol

☐ Acetaminophen
☐ Diphenhydramine
☐ Methylprednisolone_____mg
☐ Other_____

mg PO prior to infusion
mg ☐ PO ☐ IV
IV over _____ min.

Flush Protocol
* NaCl 0.9% 10mL
* Before and 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 SIGH - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED