

Pharmacy Name: Address: City/State/Zip: Phone:

Fax: Email:

Gastroenterology Referral Form										
Please attach copy of insurance cards (front and back)										
Last Name:	First Name	: DOB:				Practice:				
Address:						Address:				
City:	State:	Zip:	Sex:	М	F	City:	State:	Zip:		
Phone:	SS	N #:				Prescriber Name:				
Insurance Plan						Prescriber NPI:				
Insurance Plan:	Ins	ırance Plan:				Nurse/Key Contact:				
Policy #:	licy #: Policy #:					Phone:				
Plan #:	Pla		Fax: Email:							
Diagnosis and Clinical Information										
Please attach clinical/progress notes, labs, test supporting primary diagnosis										
Crohn's disease Diagnosis code:			TB/PPD Test: Positive Negative Date:							
Ulcerative colitis Diagnosis code:			Allergies:							
	Allergies.									
Other:										
Currently received and/or prior filed therapies: NKDA										
Length of treatme	nt:									
Reason for discon	tinuation:									
Site of care: Home AIC Other:										
Prescription Information										
Medication	Dose/Strength Directions							Refills		
Cimzia (certolizumab egol)	200mg vial (only)	☐ INITIAL: Infuse 400 mg at week 0, 2 and 4, then every 4 weeks thereafter								
Entyvio (vedolizumab)	300mg vial	☐ INITIAL: Infuse 300mg IV at week 0, 2, 6, then every 8 weeks thereafter ☐ MAINTENTANCE: Infuse 300mg IV every weeks								
☐ Omvoh	300mg/15mL 100mg/mL Prefilled syringe 100mg/mL Prefilled pen	☐ INITIAL: 300mg IV: (3) 300mg induction doses, at week 0, 4 and 8 ☐ MAINTENANCE: Inject 200mg subcutaneously at week 12 and every 4 weeks thereafter								
Remicade (infliximab) Brand name only Substitution allowed Inflectra Renflexis Avsola	☐ 100mg vial	□ INITIAL: Infuse mg/kg IV at week 0, 2, 6, then every 8 weeks thereafter □ MAINTENTANCE: Infuse mg/kg IV every weeks □ Other □ Pharmacist will round to the nearest 100mg □ Give exact dose (do NOT round)								
Stelara (ustekinumab)	130mg / 26mL vial 90mg (2x 45mg vials)	☐ INITIAL: weight based dosing, infuse IV ☐ 55kg or less: 260mg (2 vials) ☐ Greater than 85kg: 520mg (4 vials) ☐ MAINTENTANCE: Inject 90mg SQ 8 weeks after initial dose, then every 8 weeks thereafter								
Skyrizi (risankizumab)	600mg / 10mL vial Crobins disease - Inflace over 60 minutes 1200mg (2x 600mg vials) Uterative colits - Inflace over 120 minutes 180mg / 1.2mL 360mg / 2.4mL	☐ INITIAL: Infuse 600mg IV at week 0, 4, and 8 ☐ INITIAL: Infuse 1200mg IV at week 0, 4, and 8 ☐ MAINTENANCE: Inject 180mg subcutaneously at week 12 and every 8 weeks thereafter ☐ MAINTENANCE: Inject 360mg subcutaneously at week 12 and every 8 weeks thereafter								
☐ Tremfya	IV Starter Dose: 200mg 100mg/mL One Press 100mg/mL Prefilled syringe 200mg/2mL Prefilled pen 200mg/mL Prefilled syringe	☐ INITAL: 200mg IV at week 0, 4 and 8 (one-hour infusion) ☐ MAINTENANCE: Inject 100mg subcutaneously at week 16 and every 8 weeks thereafter ☐ MAINTENANCE: Inject 200mg subcutaneously at week 12 and every 4 weeks thereafter								
☐ Other										
Pre-medication and other medications Acetaminophen 250mL 0.9%NaCl for hydration mg P0 prior to infusion Flush protocol -Infusion supplies as per protocol Diphenhydramine Other mg P0 IV IV - NaCl 0.9% 10mL - Before and after infusion - Before and after infusion										
l 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 that 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 prothibited 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.