vitalcare INFUSION SERVICES of CROWN POINT

Crown Point
Phone: 219.295.4080
Fax: 219.600.1800

Specialty Infusible Medication Referral Form

Patient Information		**Prescriber Information**	
Patient Name		Prescriber Name	
Address		Practice Name	
City, State, Zip		Address	
Home Phone		City, State, Zip	
Alternate Phone		Phone / Fax	
SS#		Office Contact	
DOB / Gender		Office Contact Phone	
Alternate Contact		DEA # / NPI	
Relationship / Phone		State Lic # / UPIN #	

Insurance Information (Please copy and attach the FRONT and BACK of insurance and prescription drug card)

Clinical Information (To expedite PA process, please fax recent notes, labs, and tests with prescription)

Primary Diagnosis/ICD10 ____ Diagnosis Date ____ Height (in) ____ Weight (lbs) ____

Access: ☐ Peripheral IV ☐ PICC ☐ Implant Port ☐ Broviac/Hickman Last Infusion Date ____ Next Infusion Date ____

Negative TB Test: ☐ Yes ☐ No Date of Test: ____ Immunizations current ☐ Yes ☐ No

Prior Therapy & Dates of use ____

Allergies: ☐ NKDA ☐ Other: ____

Prescription Information

Medication Name: (check One)

☐ Remicade® ☐ Inflectra® ☐ Renflexis® ☐ Stelara® ☐ Simponi Aria® ☑ Entyvio® ☐ Cimzia® ☐ Skyrizi® ☐ Vyepti®

☐ Omvoh® ☐ Infliximab doses will be rounded to the nearest 100mg vial unless this box is checked

Directions

Dose: _____ mg/kg Total dose: 300 mg Quantity: _____ Refills: 1 year

Directions: Entyvio 300mg IV on week 0, 2, 6, and then every 8 weeks

Administration ☑ ate: ☐ Per Prescribing ☐ Information, as tolerated ☐ Other:

Pre-Medications

☑ Acetaminophen 650 mg 30 minutes prior to infusion PO ☑ Diphenhydramine 25 mg 30 minutes prior to infusion ☑ PO ☐ IV

☐ Solu-Cortef _____mg slow IVP ☐ Solu-Medrol _____mg slow IVP Administered: ☑ Pre ☐ Halfway ☐ Upon Completion

Flushing Protocol

☑ Sodium Chloride 0.9% 5-10mL pre and post medications ☐ Heparin_____Units/mL _____mL as needed

Anaphylaxis Orders and Medications

Orders: 1. Stop Infusion 2. Call 911 and prescribing physician 3. Administer medications per protocol

Diphenhydramine 50mg/mL slow IVP/IM—Administer 12.5mg (wt.<15kg), Administer 25mg (wt.15-30kg), Administer 50mg (wt. > 30kg)—Qty 1

Epinephrine 1mg/mL– Administer _____mg (wt. < 15kg) IM, Administer 0.15mg (wt. 15-30kg) IM, Administer 0.3mg (wt. > 30kg) IM —Qty: 2

Sodium Chloride 0.9% — Administer 250mL IV at KVO (20ml/hr)

Pump and Ancillary Supplies

☑ Pump and supplies as needed for administration and appropriate disposal of infusion materials

Skilled Nursing Visits

☑ As needed for IV access, administration and appropriate clinical monitoring

Prescriber Signature

In order for brand name product to be dispensed when generic is available, prescriber must handwrite "Dispense As Written" to prohibit substitution. By signing below, I certify that the above therapy is medically necessary and that the provided medical information is accurate to the best of my knowledge. I authorize Vital Care of Crown Point to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for patient listed above. I understand that I can revoke this designation by providing notice to Vital Care of Crown Point

Prescriber's Signature ____ Date ____

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