vitalcare® INFUSION SERVICES of CROWN POINT

Crown Point
Phone: 219.295.4080
Fax: 219.600.1800

Specialty Infusible Medication Referral Form

Patient Information

Patient Name _____
Address _____
City, State, Zip _____
Home Phone _____
Alternate Phone _____
SS# _____
DOB _____ Gender _____
Alternate Contact _____
Relationship _____ Phone _____

Prescriber Information

Prescriber Name _____
Practice Name _____
Address _____
City, State, Zip _____
Phone _____ Fax _____
Office Contact _____
Office Contact Phone _____
DEA # _____ NPI _____
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: _____mg Quantity: _____ Refills: 1 year

Directions: _____

Administration Rate: ☑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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