vitalcare of AUBURN HILLS

VITAL CARE OF AUBURN HILLS (0429)
Address: 1532 N Opdyke Road, Suite 700
City/State/Zip: Auburn Hills, Michigan 48326

RHEUMATOLOGY REFERRAL ORDER FORM
Phone: (947) 886-4178
Fax: (947) 886-4655

Essential Data **To process the referral, please provide the following minimum information:**

- ☐ Patient demographic information
- ☐ Copy of insurance card (front and back)
- ☐ History and physical documentation (including documentation of infection history and diagnosis, recent hospitalizations)
- ☐ Recent medication list, IV access information, and home health agency if applicable
- ☐ Currently received and/or prior filed therapies along with lengths of treatment and/or reason for discontinuation
- ☐ TB/PPD test and Hep B test if applicable
- ☐ Any additional relevant clinical documentation (labs and tests)

Patient Demographics

Last Name:		First Name:		SSN:
Date of Birth:	Sex:	Height (cm):	Weight (kg):	
Allergies:				
Address:				
City:		State:	Zip:	
Home Phone:		Mobile Phone:		
Emergency Contact Name:		Emergency Contact Phone:		
☐ Rheumatoid Arthritis (ICD-10 M05)		☐ Lupus Erythematosus (ICD-10 L93)		
☐ Ankylosing Spondylitis (ICD-10 M45)		☐ Psoriasis (ICD-10 L40)		
☐ Gout (ICD-10 M10)		☐ Other Diagnosis/ICD-10:		
If unable to find diagnosis/ICD-10 code, please refer to ICD-10-CM (cdc.gov) for reference.				

Patient Insurance Information

Primary Insurance Name:	Secondary Insurance Name:
Policy Holder Name:	Policy Holder Name:
Relation to Policy Holder:	Relation to Policy Holder:
Member ID:	Member ID:
Group ID:	Group ID:

Prescription*

Medication	Dose/Strength	Directions
☐ Inflectra (infliximab) ☐ Remicade (infliximab) ☐ Renflexis (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 over 2-3 hours every _____ weeks (max duration of 1 year)
☐ Stelara (ustekinumab)	45mg vial	☐ INITIAL: 45 mg SQ initially, 4 weeks later, followed by 45mg every 12 weeks ☐ MAINTENANCE: 45 mg SQ every 12 weeks (max duration of 1 year) ☐ INITIAL: 90 mg SQ initially, 4 weeks later, followed by 90mg every 12 weeks ☐ MAINTENANCE: 90 mg SQ every 12 weeks (max duration of 1 year)
☐ Simponi Aria (golimumab)	50mg vial	☐ INITIAL: 2mg/kg IV at weeks 0, 4, and then every 8 weeks ☐ MAINTENANCE: 2mg/kg IV every 8 weeks (max duration of 1 year)
☐ Cimzia (certolizumab)	200mg vial	☐ INITIAL: 400mg SQ at weeks 0, 2, and 4 weeks ☐ MAINTENANCE: 200mg SQ every 2 weeks (max duration of 1 year) ☐ MAINTENANCE: 400mg SQ every 4 weeks (max duration of 1 year)
☐ Orencia (abatacept)	250mg vial	☐ INITIAL: _____mg IV ☐ every 4 weeks (max duration of 1 year) ☐ 0, 2, 4 weeks and every 4 weeks thereafter (max duration of 1 year)
☐ Krystexxa (pegloticase)	8mg vial	☐ Infuse 8mg IV over 2 hours every 2 weeks (max duration of 1 year)

Additional Management Orders*

Hydration Protocol: ☐ Per Pharmacy Protocol ☐ Per Provider Protocol _____	**Premedication Protocol** ☐ Per Pharmacy Protocol Acetaminophen 650mg oral given 30 minutes prior to infusion Diphenhydramine 25mg oral given 30 minutes prior to infusion ☐ Per Provider Protocol _____
Anaphylaxis Protocol: ☐ Per Pharmacy Protocol ☐ Per Provider Protocol _____	**Flush Protocol:** ☐ Per Pharmacy Protocol Flush 10mL of 0.9% Sodium Chloride pre and post infusion ☐ Per Provider Protocol _____
Labs Protocol: ☐ Per Pharmacy Protocol ☐ Per Provider Protocol _____	Other: _____

**Product selection permitted unless dispense as written is checked or clearly written on order form.*
**Vials will be rounded to the nearest vial if appropriate unless clearly written to dispense dose as written from provider.*
**If order is not specified, it will be considered as a one-time order and must be rewritten.*

Notes to Pharmacy

☐ First Dose to be given in home
☐ Skilled Nursing visits as required

Referring Provider Information

Ordering Provider's Name:		
NPI:	Specialty:	
Facility Name:		
Address:		
City:	State:	Zip:
Office Phone:	Office Fax:	
Dispense as Written		
Provider Signature:		Date:

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.

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