vitalcare INFUSION SERVICES of FLORENCE

Pharmacy Name: **Vital Care of Florence**
Address: **161 Dozier Blvd, Suite 100**
City/State/Zip: **Florence, SC 29501**

Phone: **843-954-0010**
Fax: **843-954-0011**
Email: **info@vcflorence.com**

Simponi Aria (Adult) Referral Form

Attach Demographic Information & Insurance Cards (front/back copies) if needed

Patient Name:	DOB: Gender:
Address:	Primary Phone:
City: State: Zip:	Alt Phone:
Email:	SSN# (last 4 # required):
Weight (required): Height (required): ft in	Home Medication List Attached: ☐
☐ NKA Allergies:	☐ Allergy list attached

Diagnosis & Clinical Documentation ICD-10 Code: *

** Please attach CLINICAL PROGRESS NOTES, TESTS, LABS, HISTORY OF ATTEMPTED/FAILED TREATMENTS to support diagnosis & treatment**

☐ Rheumatoid Arthritis (RA)
☐ Psoriatic Arthritis (PsA)
☐ Ankylosing Spondylitis (AS)

☐ Negative TB Screening **(REQUIRED)**, date ordered:
☐ Negative Hepatitis Screening **(REQUIRED)**, date ordered:

Premedication(s) given 30 minutes prior to treatment:

☐ Acetaminophen _____ mg PO
☐ Cetirizine 10 mg PO
☐ Fexofenadine PO ☐ 60mg ☐ 180mg
☐ Loratadine 10 mg PO
☐ Diphenhydramine _____ mg ☐ PO ☐ IV
☐ Methylprednisolone _____ mg IV
☐ Famotidine mg ☐ PO ☐ IV

Ancillary Orders as per Protocol

* Infusion Supplies as required
* Start Peripheral IV/Access VAD as required
* NaCl 0.9% flushing/locking as required
* Heparin flushing/locking as required

Prescription Information

☑ Refills x 12 months unless otherwise noted here:

Medication	Dosing and Frequency	Standard Protocol
Simponi Aria (golimumab)	☐ Initial: Infuse 2mg/kg IV at week 0 and week 4, and every 8 weeks thereafter. ☐ Maintenance: Infuse 2mg/kg IV every 8 weeks. ☐ Other:	Dilution in 100ml NS administered IV over at least 30 minutes

Specify past/current biologic treatment attempted/failed:

Last known dose: ☐ No washout period required ☐ Provider request washout period of:

Clinical Lab Orders: Frequency:

Additional Orders/Instructions:

Anaphylaxis & Adverse Reaction Orders

*Administer anaphylaxis medications as per the Standing Adverse Reaction Protocol provided by Vital Care of Florence, access on our website or via QR code.

Physician Information

Prescriber Name:	DEA#:	License #:
Name of Practice:	Office Contact:	
Address:	City, State, Zip:	
Phone #:	Fax #:	Email:

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:_____ NPI#:_____

Prescriber must MANUALLY SIGN- Stamped signatures, signature by other personnel, & computer generated signatures will not be accepted.

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