vitalcare® of the FOUR STATES

ORDER FORM

Vital Care of the Four States, 109 E Hickory St., Neosho, MO 64850
OFFICE 417-451-7900 / FAX 417-451-7915

DEMOGRAPHICS

Patient Name: _____

Address: _____

City: _____ State: ____ Zip:_____

DOB: ____/____/____ ☐ Male ☐ Female

Phone: _____

SSN: _____ Ht: _____ Wt: _____

PRESCRIBING PHYSICIAN

Name: _____

Address: _____

City: _____State: _____ Zip: _____

Phone: _____ Fax: _____

License#: _____

DEA#: _____NPI: _____

ALLERGIES / REACTIONS

_____

_____

Signature: _____

Date: _____

PHYSICIAN ORDERS

☐ **SKYRIZI** **REFILLS: _____**

☐ 600 mg/10 ml

☐ 600 mg IV at weeks 0, 4, & 8
Prior to intravenous infusion, withdraw 10 ml of SKYRIZI soklution from the vial and inject into 5% Dextrose 250 ml (600mg/10ml) for a final concentration of 2.4 mg/ml. Infuse of a minimum of 1 hour.

☐ 360mg SQ OBI

☐ Inject 360mg SQ with OBI at week 12 then every 8 weeks thereafter.

☐ **IV ACCESS**

☐ Peripheral IV - Flush with Normal Saline 5--10 ml with IV start and before & after medication

☐ Subcutaneous Port - Flush with Normal Saline 10 ml before & after medication---LOCK with Heparin 500 units (100 units/ml)

☐ **PRE-MEDICATIONS / LABS** **REFILLS: _____**

☐ Diphenhydramine ____ MG IV 30 minutes before infusion ☐ Solu-Medrol _____ MG IV 30 minutes before infusion

☐ OTHER: _____

☐ LABS: _____FREQUENCY_____

☑ Anaphylaxis Kit per Pharmacy protocol
TO BE ADMINISTERED BY THE HEALTH CARE PROVIDER PRN FOR PATIENTS RECEIVING IV MEDS IN THE HOME
Epinephrine Auto Injector 0.3mg/0.3ml IM – Repeat one time in 20 minutes if needed

☑ ADVERSE REACTION ORDERS:

Mild Reactions - Reduce rate by 1/2 at time of onset and keep reduced x30 minutes. If resolved, increase per guidelines. If not resolved, administer appropriate medication based on symptoms,
Severe Reactions - STOP infusion ✓, KVO IV Normal Saline ✓ Diphenhydramine 25/50 mg IVP over 3-5 minutes ✓
Methylprednisolone 125 mg IVP over 5 minutes ✓ Call Ambulance and Physician ✓.

DIAGNOSIS:

☐ K50.90 Crohn's Disease NOS