

Entyvio (Vedolizumab) Order Form

Patient Name: _____ Date: _____

SSN#: _____ DOB: _____ Primary Phone: _____ Work Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Diagnosis: Please fill in appropriate ICD-10 code

- | | | |
|--|--|---|
| <p>Ulcerative colitis</p> <p><input type="checkbox"/> K51.919 Ulcerative colitis, unspecified with unspecified complications</p> | <p>Crohn's disease</p> <p><input type="checkbox"/> K50.90 Crohn's disease, unspecified without complications</p> | <p>Other ICD-10 code</p> <p><input type="checkbox"/> _____</p> |
|--|--|---|

1 Patient Information: In order to service your patient and facilitate insurance authorization, please complete the following.

Attach documents to FAX (see below)

- NKDA Allergies: _____
- Ht: _____ in/cm Wt: _____ lbs/kg Male Female
- Is this the first Entyvio infusion: Yes No
- Date of last infusion: _____ Next dose due: _____
- Line type: PIV PICC Port Other: _____ Lumen #: _____

- Copy of insurance card
- Patient demographics
- Labs
- H&P
- Immunization results, include HBV and TB
- Other: _____

2 Clinical Information: ARJ policies and protocols to be provided upon request.

Initial Dosing	Maintenance Dosing	Directions	Quantity/Refills
<input checked="" type="checkbox"/> Entyvio: 300 mg/250 mL NS IV at week 0, 2 and 6	<input checked="" type="checkbox"/> 300 mg/ 250 mL NS IV every 8 weeks	<input checked="" type="checkbox"/> Infuse per manufacturer guidelines	Dispense: 1 month supply on all selected medications Refill x12 months unless otherwise noted <input type="checkbox"/> Other: _____
<input checked="" type="checkbox"/> RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per ARJ Policy and Procedure <input type="checkbox"/> Give premedication 30 minutes prior to infusion (Note: If nothing is checked, no premeds will be given) Diphenhydramine: <input type="checkbox"/> 25-50 mg po OR <input type="checkbox"/> 50 mg IV diluted in D5W or NS 50-100mL, infuse over 10-15 mins. Antihistamine: <input type="checkbox"/> Fexofenadine 180 mg po OR <input type="checkbox"/> Cetirizine 10 mg po Methylprednisolone: <input type="checkbox"/> 125 mg slow IV push over 5 mins. OR <input type="checkbox"/> _____ mg slow IV push over 5 mins. Acetaminophen: <input type="checkbox"/> 325-650 mg po OR <input type="checkbox"/> _____ mg po <input checked="" type="checkbox"/> Flush line with NS 30 mL post infusion. <input checked="" type="checkbox"/> RN to educate patient on possible side effects, allergic reactions, and when to contact physician. <input checked="" type="checkbox"/> RN to instruct patient to hydrate pre/post infusion. RN to instruct patient to take Diphenhydramine 25-50 mg po and Acetaminophen 325-650 mg po every 4-6 hours for 24-48 hours as needed to prevent/treat post infusion headache. <input type="checkbox"/> Other: _____		<p>Adverse Reaction Orders: (Dispense 1 dose of each medication below)</p> <p>In the event of infusion reaction (fever, dyspnea, rash, increased BP or HR) the following orders will be followed and physician will be notified.</p> <p>Note: For mild reactions, patient may be treated, and infusion resumed at a slower rate.</p> <input checked="" type="checkbox"/> STOP infusion. Infuse D5W or NS at 20 mL/hr to keep line open, may increase to 100-250 mL/hr for hydration. May give the following if stopping infusion does not resolve symptoms: <input checked="" type="checkbox"/> Diphenhydramine 50 mg IV diluted in D5W or NS 50-100 mL, infused over 10-15 minutes or 50 mg/10 mL NS IV push over 2-3 minutes, as tolerated. <input checked="" type="checkbox"/> Methylprednisolone 125 mg (OR _____ mg) slow IV push over 5 minutes. <input checked="" type="checkbox"/> Acetaminophen 325-650 mg (OR _____ mg) po at onset of symptoms. <input checked="" type="checkbox"/> Epinephrine (1:1000) by weight for use IM or SQ in anaphylactic reaction. May repeat one time. EMS/911 will be called if used.	

3 Prescriber Information: By signing I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. ARJ Infusion Services has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.

Physician Name: _____ Office Contact: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Fax: _____

License #: _____ DEA#: _____ NPI #: _____

Date: _____

Physician Signature Required - Substitution Permitted
Physician Signature Required - Dispense as Written

Confidential Health Information: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization and under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure of this information is prohibited by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law. Important Warning: This message is intended for the use of the person or entity to who it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any discrimination, distribution, or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately.