ARJ Infusion SERVICES

FAX completed form to ARJ (877) 451-8955
Intake Specialist (866) 451-8804
referral@arjinfusion.com
arjinfusion.com/referrals

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*

Ulcerative colitis
☐ **K51.919** Ulcerative colitis, unspecified with unspecified complications

Crohn's disease
☐ **K50.90** Crohn's disease, unspecified without complications

Other ICD-10 code
☐ _____
_____

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

☐ 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 #: _____

Attach documents to FAX *(see below)*

☒ 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
☒ **Entyvio:** 300 mg/250 mL NS IV at week 0, 2 and 6	☒ 300 mg/ 250 mL NS IV every 8 weeks	☒ Infuse per manufacturer guidelines	Dispense: 1 month supply on all selected medications Refill x12 months unless otherwise noted ☐ *Other:* _____

☒ RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per ARJ Policy and Procedure

☐ **Give premedication 30 minutes prior to infusion** *(Note: If nothing is checked, no premeds will be given)*

Diphenhydramine: ☐ 25-50 mg po **OR** ☐ 50 mg IV diluted in D5W or NS 50-100mL, infuse over 10-15 mins.

Antihistamine: ☐ Fexofenadine 180 mg po **OR** ☐ Cetirizine 10 mg po

Methylprednisolone: ☐ 125 mg slow IV push over 5 mins. **OR** ☐ _____ mg slow IV push over 5 mins.

Acetaminophen: ☐ 325-650 mg po **OR** ☐ _____ mg po

☒ Flush line with NS 30 mL post infusion.

☒ RN to educate patient on possible side effects, allergic reactions, and when to contact physician.

☒ 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.

☐ Other: _____

_____

Adverse Reaction Orders: *(Dispense 1 dose of each medication below)*

In the event of infusion reaction (*fever, dyspnea, rash, increased BP or HR*) the following orders will be followed and physician will be notified.

Note: For mild reactions, patient may be treated, and infusion resumed at a slower rate.

☒ **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:

☒ **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.

☒ **Methylprednisolone**
125 mg (**OR** _____ mg) slow IV push over 5 minutes.

☒ **Acetaminophen**
325-650 mg (**OR** _____ mg) po at onset of symptoms.

☒ **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: _____ | _____ Date: _____

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