ENTYVIO
(vedolizumab)

FAX to + 1 208.963.3245 or
Email to intake@infusionspecialists.org
To ensure processing of your order, please complete all fields.

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:________________ lbs or____________kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- Tried/Failed Therapies
- Negative TB Results

PRIMARY DIAGNOSIS

☐ K50.00 Crohn's disease of small intestine without complications
☐ K50.10 Crohn's disease of large intestine without complications
☐ K50.90 Crohn's disease, unspecified without complications
☐ K51.00 Ulcerative (chronic) pancolitis without complications
☐ K51.90 Ulcerative colitis, unspecified without complications
☐ Other: ____________________

PRE-MEDICATIONS

☑ Per infusion clinic protocol: There are no recommended standard pre-meds for Entyvio
☐ Provider Prescribed: ____________________

PRIMARY MEDICATION ORDER

☐ Entyvio 300mg IV at weeks 0, 2, 6, and every 8 weeks thereafter.
☐ Entyvio 300mg IV every ______weeks.
☐ Other: ____________________

*If using SubQ maintenance dosing (must have received 2 IV doses to be eligible):
☐ Infusion clinic to coordinate with Specialty Pharmacy: Entyvio 108mg SubQ every 2 weeks
☐ Provider to coordinate with Specialty Pharmacy

First Dose: ☐Y ☐N ☑ Refill x12 months unless otherwise noted: ____________________

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Infusion Specialists' protocol (See infusionspecialist.org for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Infusion Specialists' protocol (See infusionspecialist.org for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

____________________ Provider Signature

____________________ Date