KabaFusion
Patient-Focused Infusion Therapy

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# ENTYVIO (VEDOLIZUMAB) PATIENT REFERRAL AND PRESCRIPTION SHEET

| Patient Information | | |
|---|---|---|
| **Patient Name:** | **Date:** | |
| **DOB:** | **Height:** | ❑ **inches** ❑ **cm** |
| **Allergies:** | **Weight:** | ❑ **lbs** ❑ **kg** |

| Primary Diagnosis | | | |
|---|---|---|---|
| **Diagnosis** | **ICD-10** | **Diagnosis** | **ICD-10** |
| ❑ Adult Ulcerative Colitis (UC) | K51.90 | ❑ Moderate to Severe Crohn's Disease | K50.01 |
| ❑ Other: | | | |

## Medication Order

**IV Regimen**
❑ Initial dose: Infuse 300mg IV over at least 30 min on Weeks 0,2 and 6
❑ Maintenance Dose: Infuse 300mg IV over at least 30 min every 8 weeks
❑ Other _____

**IV to SC Regimen**
❑ Initial IV induction dose: 300mg IV over at least 30 min on Weeks 0 and 2
❑ Maintenance Dose: Inject Prefilled pen or syringe of 108mg SC every 2 week
❑ Other _____

❑ Refills x one year from date of signature unless indicated below

❑ _____ Refills

**Nursing Orders**
Skilled nursing visits for assessment, administration of and/or teach self-administration of medication as appropriate. Initiate plan of treatment for ongoing nursing services. Insert or access and maintain access device as indicated in Ancillary Orders**.** Remove peripheral IV or access from implanted VAD when infusion is completed.

## Ancillary Orders

**Pre-medications:**
❑ Diphenhydramine: 25mg PO 30 min pre-infusion
❑ Acetaminophen: 650mg PO 30 min pre-infusion
❑ Famotidine: 20 mg PO x1 dose
❑ Other pre-meds: _____
❑ **Refill x one year**

**IV Flush Orders:**
❑ Peripheral: NS 1-3 mL before/after use
❑ Implanted VAD: NS 5 to 10 mL before/after use and 10 mL post-lab draw. Heparin (100 unit/mL) 3 to 5 mL final flush
❑ CVAD: NS 5 to 10 mL before/after use and 10 mL post-lab draw Heparin (10 units/mL) 3 to 5 mL final flush
❑ **Refill x one year**

❑ **Anaphylaxis Protocol: Epinephrine Auto-Injector dual pack:** Adult: 0.3mg Children: 0.15 mg
Administer epinephrine IM in the event of anaphylaxis. May repeat x 1 as needed, Call 911. **Refill x 1yr**

| Therapy Specific Documentation | Other Required Documentation |
|---|---|
| **Please include the following lab results required for infusion.**<br>❑ CDAI Index Score<br>❑ QuantiFERON-TB Gold<br>❑ Hep B Screening<br>❑ CMP, CBC and LFTs<br>❑ Other: | ❑ Patient Demographics – include insurance information. We will obtain authorization unless the insurance dictates otherwise.<br>❑ H&P OR progress note(s)<br>❑ Medication List (include prior/failed DMARDS, biologics, or steroid use) |

| Provider Information | |
|---|---|
| **Provider Name:** | **Provider Phone:** |
| **Provider NPI:** | **Provider Fax:** |
| **Provider Address:** | |

I authorize KabaFusion and its representatives to act as an agent and initiate and execute any insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to KabaFusion.

Prescriber Signature: _____ Date: _____