

**ENTYVIO (VEDOLIZUMAB) PATIENT REFERRAL AND PRESCRIPTION SHEET**

Patient Information			
<b>Patient Name:</b>		<b>Date:</b>	
<b>DOB:</b>		<b>Height:</b>	<input type="checkbox"/> inches <input type="checkbox"/> cm
<b>Allergies:</b>		<b>Weight:</b>	<input type="checkbox"/> lbs <input type="checkbox"/> kg

  

Primary Diagnosis			
<b>Diagnosis</b>	<b>ICD-10</b>	<b>Diagnosis</b>	<b>ICD-10</b>
<input type="checkbox"/> Adult Ulcerative Colitis (UC)	K51.90	<input type="checkbox"/> Moderate to Severe Crohn's Disease	K50.01
<input type="checkbox"/> Other: _____			

  

Medication Order	
<b>IV Regimen</b> <input type="checkbox"/> Initial dose: Infuse 300mg IV over at least 30 min on Weeks 0,2 and 6 <input type="checkbox"/> Maintenance Dose: Infuse 300mg IV over at least 30 min every 8 weeks <input type="checkbox"/> Other _____ <b>IV to SC Regimen</b> <input type="checkbox"/> Initial IV induction dose: 300mg IV over at least 30 min on Weeks 0 and 2 <input type="checkbox"/> Maintenance Dose: Inject Prefilled pen or syringe of 108mg SC every 2 week <input type="checkbox"/> Other _____	<input type="checkbox"/> Refills x one year from date of signature unless indicated below  <input type="checkbox"/> _____ 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	
<b>Pre-medications:</b> <input type="checkbox"/> Diphenhydramine: 25mg PO 30 min pre-infusion <input type="checkbox"/> Acetaminophen: 650mg PO 30 min pre-infusion <input type="checkbox"/> Famotidine: 20 mg PO x1 dose <input type="checkbox"/> Other pre-meds: _____ <input type="checkbox"/> <b>Refill x one year</b>	<b>IV Flush Orders:</b> <input type="checkbox"/> Peripheral: NS 1-3 mL before/after use <input type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> <b>Refill x one year</b>
<input type="checkbox"/> <b>Anaphylaxis Protocol: Epinephrine Auto-Injector dual pack:</b> Adult: 0.3mg Children: 0.15 mg Administer epinephrine IM in the event of anaphylaxis. May repeat x 1 as needed, Call 911. <b>Refill x 1yr</b>	

  

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

  

Provider Information	
<b>Provider Name:</b>	<b>Provider Phone:</b>
<b>Provider NPI:</b>	<b>Provider Fax:</b>
<b>Provider Address:</b>	

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: \_\_\_\_\_