



Prescriber Signature: \_\_\_\_

ENTYVIO (VEDO				AND PRESCRIPTION	N SHE	ET.
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 t	Crohn's Disease		K50.01	
☐ Other:						
Medication Order						
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						m date of nature unless icated below  Refills ate. Initiate plan of
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.  CDAI Index Score QuantiFERON-TB Gold Hep B Screening CMP, CBC and LFTs Other:			<ul> <li>□ Patient Demographics – include insurance information. We will obtain authorization unless the insurance dictates otherwise.</li> <li>□ H&amp;P OR progress note(s)</li> <li>□ Medication List (include prior/failed DMARDS, biologics, or steroid use)</li> </ul>			
Provider Information						
Provider Name:				Provider Phone:		
Provider NPI:				Provider Fax:		
Provider Address:						
authorize KabaFusion and its representatives to act as an a for the patient listed above. I understand that I can revoke the					nd any futi	ure refills of the same prescription

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Date: \_\_\_