



Prescriber Signature: ___

ENTYVIO (VEDOLIZUMAB) PATIENT REFERRAL AND PRESCRIPTION SHEET								
		Patient Inf	ormation					
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			's Disease		K50.01	
☐ Other:								
Medication Order								
IN 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 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							n date of nature unless cated below Refills ate. Initiate plan of	
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. CDAI Index Score QuantiFERON-TB Gold Hep B Screening CMP, CBC and LFTs Other:			 □ Patient Demographics – include insurance information. We will obtain authorization unless the insurance dictates otherwise. □ H&P OR progress note(s) □ Medication List (include prior/failed DMARDS, biologics, or steroid use) 					
Provider Information								
Provider Name:				Provider Phone:				
Provider NPI:				Provider Fax:				
Provider Address:								
authorize KabaFusion and its representatives to act as an a	•	•	•			nd any futu	re refills of the same prescription	

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