



Prescriber Signature: ___

ENTYVIO (VEDOLIZUMAB) PATIENT REFERRAL AND PRESCRIPTION SHEET						
Patient Information						
Patient Name:				Date:		
DOB:				Height:		☐ inches ☐ cm
Allergies:				Weight:	Weight:	
Primary Diagnosis						
Diagnosis ICD-10 Diagnosis				ICD-10		
☐ Adult Ulcerative Colitis (UC)	K51.90	☐ Moderate t	to Severe	Crohn's Disease		K50.01
☐ Other:						
Medication Order						
I 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					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	are refills of the same prescription

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Date: ___