



Prescriber Signature: ___

ENTYVIO (VEDOLIZUMAB) PATIENT REFERRAL AND PRESCRIPTION SHEET

ENTIVIO (VEDULIZUMAB) PATIENT REFERRAL AND PRESCRIPTION SHEET					
Patient Information					
Patient Name:			Date:		
DOB:			Height:	Height:	
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					
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					
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 Au Administer epinephrine IM in the even		_	_		
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 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.					

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Date: ___