

ENTYVIO (VEDOLIZUMAB) PATIENT REFERRAL AND PRESCRIPTION SHEET

Patient Information						
Patient Name:			Date:	Date:		
DOB:			Height:		□ inches □ cm	
Allergies:			Weight:	Weight:		
Primary Diagnosis						
Diagnosis	ICD-10	Diagnosis		ICD-10		
Adult Ulcerative Colitis (UC)	Ulcerative Colitis (UC) K51.90 G Mode		erate to Severe Crohn's Disease		К50.01	
Other:	'					
Medication Order						
 IV 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			ration of medication as a	 Refills x one year from date of signature unless indicated below Refills 		
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						
 Diphenhydramine: 25mg PO 30 min pre-infusion Acetaminophen: 650mg PO 30 min pre-infusion Famotidine: 20 mg PO x1 dose Other pre-meds:			 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:						

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:

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