immersiv HEALTH

# ENTYVIO® ORDER FORM

**FAX TO: 855.694.4656**

## PATIENT INFORMATION

**PATIENT NAME:** _____ **PHONE:** _____

**DATE OF BIRTH:** _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

**ALLERGIES:** _____ **PREFERRED CLINIC:** _____

**REFERRAL STATUS:** ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

## DIAGNOSIS & CLINICAL DOCUMENTATION

- ☐ K50.00 Crohn's Disease – small intestine
- ☐ K50.10 Crohn's Disease – large intestine
- ☐ K50.80 Crohn's Disease – small & large intestine
- ☐ K50.90 Crohn's Disease, unspecified
- ☐ K51.00 Universal Ulcerative Pancolitis–chronic
- ☐ K51.50 Left sided Ulcerative Colitis – chronic
- ☐ K51.80 Other Ulcerative Colitis – chronic
- ☐ K51.90 Ulcerative Colitis

☐ ICD-10 CODE: _____ DESCRIPTION: _____

## REQUIRED DOCUMENTATION

☐ Insurance Information ☐ List of Medications ☐ Tried & Failed Therapies ☐ Most Recent History & Physical

## MEDICATION ORDER

☐ **LOADING:** Entyvio® (vedolizumab) 300mg IV in 250ml NS over 30 minutes at week 0, 2, and 6

☐ **MAINTENANCE:** Entyvio® (vedolizumab) 300mg IV in 250ml NS over 30 minutes every 8 weeks

☐ **OTHER:** _____

*Flush with 30ml NS after each infusion

☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

### PRE-MEDICATIONS

**PO**

- ☐ Acetaminophen: 650 mg
- ☐ Cetirizine: 10 mg
- ☐ Diphenhydramine: 25 mg

**IV**

- ☐ Methylprednisolone: 125 mg
- ☐ Diphenhydramine: 25 mg

☐ **OTHER:** _____ ☐ PO ☐ IV

Patient to be observed for 30 minutes following the first administration.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

## PRESCRIBER INFORMATION

**PROVIDER NAME:** _____ **NPI #:** _____

**EMAIL:** _____ **PHONE:** _____ **FAX:** _____

**ADDRESS (INCLUDE CITY, STATE, ZIP):** _____

**SUPERVISING PHYSICIAN:** _____ **CONTACT NAME:** _____
(IF APPLICABLE)

**SIGNATURE:** _____ _____ **DATE:** _____
(NO STAMPS)
SUBSTITUTION PERMITTED DISPENSE AS WRITTEN