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. Administer per protocol.
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: ______________________
(IF APPLICABLE)

CONTACT NAME: ______________

SIGNATURE: ______________ | ______________ DATE: __________
(NO STAMPS)

SUBSTITUTION PERMITTED DISPENSE AS WRITTEN