

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M / F Ht: _____ Wt: _____ lbs / kg
Primary Language: _____ Allergies: _____
Patient Preferred Location: _____

<ICD 10 CODE REQUIRED>

DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE)

- | | |
|---|---|
| <input type="checkbox"/> K50.0 _____ Crohn's Disease, Small Intestine | <input type="checkbox"/> K51.8 _____ Other Ulcerative Colitis, Chronic |
| <input type="checkbox"/> K50.1 _____ Crohn's Disease, Large Intestine | <input type="checkbox"/> K51.5 _____ Left Sided - Ulcerative Colitis, Chronic |
| <input type="checkbox"/> K50.8 _____ Crohn's Disease, Small & Large Intestine | <input type="checkbox"/> K51.0 _____ Universal Ulcerative Pancolitis, Chronic |
| <input type="checkbox"/> K50.9 _____ Crohn's Disease, Unspecified | <input type="checkbox"/> K51.9 _____ Ulcerative Colitis, Unspecified |
- Other: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.
LAB RESULTS: Include Negative TB within 12 months.

PRESCRIPTION

Pre-Medications

- Acetaminophen: 650 mg PO
 - Cetirizine: 10 mg PO
 - Diphenhydramine: 25 mg PO
 - Diphenhydramine: 25 mg IVP
 - Famotidine: 20 mg PO
 - Methylprednisolone: 125 mg SIVP
- Other: _____

Lab Orders+

Required: Negative TB, annually
+Medix Infusion will draw maintenance labs unless otherwise directed by Referring Provider.

Entyvio (vedolizumab)

Loading Dose:

- IV:** Infuse 300 mg in 250 mL of 0.9% Sodium Chloride over at least 30 minutes at weeks 0, 2, 6

Maintenance Dose: (SELECT ONE)

- IV:** Infuse 300 mg in 250 mL of 0.9% Sodium Chloride over at least 30 minutes every 8 weeks for one year
- IV:** Infuse 300 mg in 250 mL of 0.9% Sodium Chloride over at least 30 minutes every _____ weeks for one year

Following each infusion, flush with 30 mL 0.9% Sodium Chloride.

In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

Post Treatment Observations: The patient is observed for 30 minutes following the first infusion.

Comments: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ *Signature:* _____
Date: _____ NPI #: _____ Specialty: _____
Supervising Physician: _____ (If Applicable)
Address: _____ City: _____ State: _____ Zip: _____
Contact Name: _____ Phone: _____ Fax: _____ Email: _____