

Patient Information

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

Diagnosis

ICD 10 Code (PROVIDE COMPLETE CODE)

K50.0 _____ Crohn's Disease, Small Intestine	K51.8 _____ Other Ulcerative Colitis, Chronic
K50.1 _____ Crohn's Disease, Large Intestine	K51.5. _____ Left Sided - Ulcerative Colitis, Chronic
K50.8 _____ Crohn's Disease, Small & Large Intestine	K51.0. _____ Universal Ulcerative Pancolitis, Chronic
K50.9 _____ Crohn's Disease, Unspecified	K51.9 _____ Ulcerative Colitis, Unspecified

Other ICD 10 Code: _____
 Description _____

Infusion Orders

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+

Requested Add'l Lab Orders:

Lab Frequency: _____ every _____ weeks

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

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

Comments: _____

Required Clinical Documentation

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.

Is the patient on any other disease modifying therapy?

Yes No

If yes, please note therapy and last dose:

LAB RESULTS: Negative TB result (QuantiFeron Gold, T-spot, PPD, TST, CXR) W/in 1Y of therapy initiation, thereafter annual screening by questionnaire

Medix Infusion will collect all necessary labs if not included in referral document.

Referring Provider Information

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