Entyvio® Order Form
(vedolizumab)

FAX TO: 972.499.9210

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
☐ K50.1 _____ Crohn's Disease, Large Intestine
☐ K50.8 _____ Crohn's Disease, Small & Large Intestine
☐ K50.9 _____ Crohn's Disease, Unspecified
☐ Other ICD 10 Code: _____
Description _____

☐ K51.8 _____ Other Ulcerative Colitis, Chronic
☐ K51.5. _____ Left Sided - Ulcerative Colitis, Chronic
☐ K51.0. _____ Universal Ulcerative Pancolitis, Chronic
☐ K51.9 _____ Ulcerative Colitis, Unspecified

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% Sdoium 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

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

Is the patient on any other disease modifying therapy?
☐ Yes ☐ No
If yes, please note therapy and last dose:
_____

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

Referring Provider Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in deaing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____ Date: _____

Prescriber Name: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____