Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:	
☐ New referral	☐ Order change	☐ Order Renewal	
Patient preferred clinic:			

Entyvio® (vedolizumab) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:				Patient's Phone:			
Patient Name:				Address:			
Date of Birth:				City, State, Zip:			
Height in inches:	Weight: LB or KG			Gender:	Allergies: ☐	See list ☐	NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	K50.0____ - Crohn's Disease (small intestine)	☐	K50.9____ - Crohn's Disease, Unspecified
☐	K50.1____ - Crohn's Disease (large intestine)	☐	K51.8____ - Other Ulcerative (chronic) Colitis
☐	K50.8____ - Crohn's Disease (small & large intestine)	☐	K51.5____ - Left sided Ulcerative (chronic) Colitis
☐	K51.0____ - Universal Ulcerative (chronic) Pancolitis	☐	K51.0____ - Universal Ulcerative (chronic) Pancolitis
☐	_____ - Other:_____		

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	
6	

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO:

PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF YES:

LAST INFUSION DATE:

NEXT INFUSION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive vedolizumab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new onset or deterioration neurological changes, and/or surgery.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMNISTRATION AS SELECTED

IV	Diphenhydramine	☐ 25mg	☐ 50mg						
	Methylprednisolone	☐ 40mg	☐ 125mg	☐ Other:					
	Famotidine	☐ 20mg	☐ 40 mg						
	Other:	☐							
PO	Acetaminophen	☐ 325mg	☐ 500mg	☐ 650mg	☐ 1000mg				
	Famotidine	☐ 20mg	☐ 40mg						
	Diphenhydramine	☐ 25mg	☐ 50mg						
	Fexofenadine	☐ 60mg	☐ 180mg						
	Cetirizine	☐ 10mg							
	Loratadine	☐ 10mg							
	Other:	☐							

MEDICATION/DOSE:

☑ Entyvio® (vedolizumab) 300mg per 250ml NS IV to infuse over at least 30 minutes

FREQUENCY:

☐ Induction: Dosed at week 0, week 2, week 6, and every 8 weeks thereafter

☐ Induction: _____

☐ Maintenance: Dosed every 8 weeks

☐ Maintenance: Dosed every ___ weeks

SPECIAL/LAB ORDERS:

☐ _____

_____

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures) DATE:

Dispense as written/Brand medically necessary	Substitution permitted	