Intravene – ENTYVIO Infusion Orders (rev 10/2018)

Please fax this form along with a copy of insurance cards and clinical documentation to: (434)455-5531 or call (434)947-3900 ext. 2172

PATIENT INFORMATION

Name _____
Address _____
City _____
State _____ Zip Code _____
Home Phone # _____
Work Phone # _____
DOB _____SSN _____
Height _____ Weight _____lbs
Drug Allergies_____
□ NKDA Sex: □ Male or □ Female

REFERRING PHYSICIAN INFORMATION

Physician Name _____
Physician Address_____
_____
Physician Phone(_____)_____
Physician Fax(____)_____
NPI#_____DEA#_____
State License#_____

****Please fax copies of insurance cards** and this form to 434-455-5531**

DIAGNOSIS: (ICD-10 required)

Crohn's Disease

☐ _____
☐ _____
☐ _____

Ulcerative Colitis

_____
_____
_____

PRE TREATMENT SCREENING:

☐ Tuberculosis Screening: Date/Results of TB test_____
☐ Hepatitis B Screening: Date/ Results:_____
☐ Hepatitis C Screening: Date/Results:_____

PRIOR MEDICATIONS TRIED AND FAILED :

Is your patient currently taking, failed or have a contraindication to any of the following products?

6- mercaptopurine-Currently Taking ☐ Failed ☐ Date Failed or contraindication _____
Aminosalicylates- Currently Taking ☐ Failed ☐ Date Failed or contraindication _____
Azathioprine- Currently Taking ☐ Failed ☐ Date Failed or contraindication _____
Corticosteroids- Currently Taking ☐ Failed ☐ Date Failed or contraindication _____
Methotrexate- Currently Taking ☐ Failed ☐ Date Failed of contraindication _____
TNF inhibitor (Humira, Remicade) Currently Taking ☐ Failed ☐ Date Failed or contraindication _____

Has patient started therapy? □ Yes □ NO If yes, last treatment date: _____/_____/_____
Prior therapy? □ Yes □ NO
If yes, please list therapy and date/duration:_____

STANDARD ORDERS: ENTYVIO 300 mg IV

DOSAGE AND DIRECTIONS FOR USE:

□ 300mg in NS 250ml to infuse over 30 minutes at week(s) 0, 2, 6 weeks and every 8 weeks thereafter for 1 year. Upon completion of Entyvio infusion, infuse Normal Saline 20ml to clear line.
□ Other _____

LABS:

□ None
□ Other_____

Anaphylactic meds and Vital Sign Monitoring per Intravene Protocol

Signature, prescribing MD _____ Date: _____