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. 3001

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_________________________

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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

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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.

□ 300mg in NS 250ml to infuse over 30 minutes every __________weeks for 1 year.

Upon completion of Entyvio infusion, infuse Normal Saline 20ml to clear line.

LABS:

□ None

□ Other____

Anaphylactic meds and Vital Sign Monitoring per Intravene Protocol

Signature, prescribing MD ____________________________ **Date:** _________________