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|--|---------------------------------------|
| Referral Status: | MRN: |
| <input type="checkbox"/> New referral | <input type="checkbox"/> Order change |
| <input type="checkbox"/> 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 | K51.9 - Ulcerative Colitis |
| - Other: | |

REQUESTED DOCUMENTATION:

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

| | | | |
|---|--------------------------------|------------------|--|
| 1 | Insurance information | IF NO: | IF YES: |
| 2 | Most recent History & Physical | PLEASE STATE | LAST INFUSION DATE: |
| 3 | Full medication list | REQUIRED WASHOUT | NEXT INFUSION DATE: |
| 4 | Tried and failed therapies | FROM PREVIOUS | IF ORDER CHANGE: |
| 5 | | THERAPY: | |
| 6 | | | |
| | | | 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 ADMINISTRATION AS SELECTED

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

MEDICATION/DOSE:

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

SPECIAL/LAB ORDERS:

FREQUENCY:

Induction: Infuse at week 0, week 2, week 6, then every 8 weeks thereafter

Induction: _____

Maintenance: Dosed every 8 weeks

Maintenance: Dosed every _____ weeks



Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

- Start PIV/Access CVC
- Flush device per facility standard flushing procedure
- Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

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 |