

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

Rev 4.28.25

PATIENT DEMOGRAPHICS:

Patient Name:	
Patient's Phone:	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	
5		THERAPY:	IF ORDER CHANGE:
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. After the infusion is complete, flush with 30ml NS.

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: ADVERSE REACTION & ANAPHYLAXIS 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

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

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



Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- Patient demographics - address, phone number, SS#, etc.**
- Insurance information - copy of the card(s) if possible**
- Plan of Treatment/Orders**
- Most recent physician office notes to include tried and failed therapies - all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- Any lab results or other diagnostic procedures to support the diagnosis.**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.palmettoinfusion.com