

Entyvio

Vedolizumab



Treatment Location: Dublin, OH Lancaster, OH

PROVIDERS: Please include the following to expedite the order: All Clinical Documentation Supporting the Diagnosis Including any Previous or Current Therapies, Pertinent Labs, or Diagnostic Testing, Most Recent Office Visit Note

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Date: Patient Name: Patient Phone: DOB:

ICD-10 code (required): K50. K51. ICD Description:

Allergies: Weight (lbs/kg): Height:

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

NURSING

Center will use Hypersensitivity protocol established by Infuse One Ohio

PRE-MEDICATION ORDERS

Pre-Medications not usually indicated.

Diphenhydramine 25mg / 50mg PO / IV
 Acetaminophen 325mg / 500mg / 650mg PO
 Other: _____
Dose: _____ Route: _____ Frequency: _____

THERAPY ADMINISTRATION

Entyvio Intravenous Infusion
Dose: 300mg
Frequency:
 Induction: Week 0, 2, and 6
 Maintenance: Every 8 weeks
 Other: _____
 Refills: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, Infuse One Ohio is authorized to administer a generic or biosimilar.

SPECIAL INSTRUCTIONS:

Provider Name (Print) Provider Signature Date

Please check this box if you DO NOT authorize Infuse One Ohio to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.