Agile Infusion Services LLC
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ENTYVIO MEDICATION ORDER

Patient's Name (Last, First, Middle) _____ DOB _____

Patient's height in feet and inches _____ *Patient's weight in pounds*_____

■ **Diagnosis** *For Crohn's disease, the most specific ICD-10 code must be completed.*
☐ K50.90 Ulcerative Colitis ☐ K50.9___ Crohn's disease (specify ICD-10 code)

■ **Details Needed for Approval** *Please answer all questions and provide supporting documentation.*

- Proof of patient's negative latent TB test. If test is positive, proof that patient has begun therapy for latent TB.
- Is patient concurrently being treated with any other biologic? _____
- Does the patient have an intolerance, contraindication or hypersensitivity to any of the following agents, or has tried and failed on at least one with at least 3 months of therapy? If yes, circle all that apply. They are: 6-mercaptopurine, aminosalicylates, azathioprine, corticosteroids, mesalamine, methotrexate, sulfasalazine, hydroxychloroquine, Otezla, NSAIDs and leflunomide.
- Please provide documented failure, contraindication, or ineffective response at maximum tolerated doses to a minimum (3) month trial on previous therapy with a TNF modifier such as Humira, Simponi, or infliximab (Avsola, Inflectra, Remicade or Renflexis).

■ **Entyvio (vedolizumab) Medication Order**
Select one or both doses required:
☐ Starting dose: 300mg in 250ml normal saline over about 30 minutes at weeks 0, 2 and 6.
☐ Maintenance dose: 300mg in 250ml normal saline over about 30 minutes every 8 weeks for _____ months.
Post infusion flush with normal saline. Check vitals and monitor for signs and symptoms at start, throughout infusion, and after completion.

■ **Rescue Management in case of Infusion Therapy Reaction**
These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Stop medication infusion and start normal saline infusion at 50 ml/hr. Call ordering provider to report reaction.
- Follow standing reaction orders, including Diphenhydramine, Methylprednisolone, Albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

■ **Ordering Provider Authorization**

Provider Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ Indiv. NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone to Contact Person: _____

FAX THIS ORDER AND SUPPORTING DOCUMENTATION TO 201-266-0437 OR UPLOAD USING YOUR SECURE DEDICATED WEBPAGE – TO GET A PERSONAL LINK PLEASE CONTACT THE INTAKE TEAM.