Web: www.AgileIV.com | Tel: (201) 751-2202 | Fax: (201) 266-0437 | Email: info@AgileIV.com

ENTYVIO MEDICATION ORDER

Patient's Name (Last, First, Middle) ________________________ DOB ____________________

Patient's height in feet and inches ______________ *Patient's weight in pounds*____________________

■ Diagnosis

These diagnoses are all without complications. For with complications please change last digit from 0 to 1.

☐ K50.00 Crohn's disease of sm intestine w/o comp
☐ K50.10 Crohn's disease of lg intestine w/o comp
☐ K50.80 Crohn's disease of both int w/o comp
☐ K50.90 Crohn's disease unspecified w/o comp
☐ K51.00 UC pancolitis w/o comp
☐ K51.20 UC proctitis w/o comp
☐ K51.30 UC rectosigmoiditis w/o comp
☐ K51.50 Left-sided colitis w/o comp
☐ K51.80 Other UC w/o comp
☐ K51.90 UC unspecified w/o comp

■ 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) IV Medication Order

Select one or both doses required:

☐ Starting IV dose: 300mg in 250ml normal saline over about 30 minutes at weeks 0, 2 and 6.
☐ Maintenance IV 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.