promptcare

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Entyvio (vedolizumab) I Order Form

Patient Name: _____ DOB: _____ Phone:_____

Address: _____ City: _____ State: _____ Zip: _____

1. For new patients, please submit with form:

☒ Copy of insurance card

☒ Patient demographics

☒ History & physical

☒ Most recent labs, TB screening if needed according to local practice

2. Patient Information

☐Male ☐Female Height: _____ in/cm Weight: _____ lbs/kg ☐NKDA Allergies: _____

Is this the first dose? ☐Yes ☐No, date of last infusion: _____ Next due: _____ Line type: ☐PIV ☐PICC ☐Port ☐Other

3. Diagnosis and Clinical Information

ICD-10 (required): _____ Primary diagnosis: ☐ Ulcerative colitis ☐ Crohn's disease ☐ Other: _____

4. Prescription Information

Medication	**Entyvio 300 mg single-dose vial**
Dose / Frequency	☐ Initial and maintenance dosing: 300 mg IV at 0, 2 and 6 weeks, then every 8 weeks ☐ Maintenance dosing only (initial dosing already complete): 300 mg IV every 8 weeks ☐ Other: _____
Directions	☒ Reconstitute and dilute Entyvio per manufacturer guidelines ☒ Infuse IV over 30 minutes. After infusion is complete, flush IV line with 30mL of 0.9% sodium chloride ☐ Other: _____
Quantity / Refills	Dispense 1 month supply / Refill x 12 months ☐Other: _____ Dispense all medical supplies necessary for infusion

5. Additional Orders

☒ RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per PromptCare policy and procedure

Premedications: Give 30 min prior to infusions (*Note: if nothing is checked, no premedications will be given*)

☐ Diphenhydramine 25-50mg PO. Patient may decline.

☐ Acetaminophen 325-650mg (OR _____ mg) PO. Patient may decline.

☐ Methylprednisolone 40 mg (OR _____mg) slow IV push (or an equivalent corticosteroid, substitution if needed by pharmacy)

☐ Other: _____

☒ RN to instruct patient to hydrate pre/post infusion and educate on taking OTC diphenhydramine and/or acetaminophen per manufacturer dosing recommendations as needed to prevent/treat post-infusion headache.

☒ RN to monitor patient for at least 30 min post infusion and educate on possible side effects, allergic reactions, and when to contact physician

6. Adverse Reaction Orders

Standard anaphylaxis kit to be dispensed and dosed per protocol: Epinephrine IM/SQ (1 mg/mL vial), diphenhydramine IV/IM (50 mg/mL vial), and NS IV. Additional orders: _____

7. Prescriber Information

Prescriber Name: _____ Office Contact: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

License No.: _____ DEA NO.: _____ NPI: _____

_____ _____ _____ _____

Physician Signature (Substitution Permitted) Date **Physician Signature (Dispense as Written)** Date

By signing I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment. PromptCare has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services