Entyvio

INFUSION FOR HEALTH

Treatment Location: ____________

PROVIDERS: Please include the following to expedite the order:
Patient Demographics, Most Recent Office Visit Note, Insurance Information, Tried & Failed Medications List

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal ☐ Home Infusion

Date: Patient Name: Patient Phone: DOB:

ICD-10 code (required): ☐ K50.9 ☐ 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 Infusion for Health and PI

☑ Tried & Failed Medications:

☐ TNF Blocker / ☐ Immunomodulator / ☐ Corticosteroids

☐ Other: ____________

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every ____________

☐ CMP ☐ at each dose ☐ every ____________

☐ Other: ☐ Frequency: ____________

☐ Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

PRE-MEDICATION ORDERS

Pre-Medications not usually indicated.

☐ Other: ____________

Dose: ________ Route: ________ Frequency: ________

SPECIAL INSTRUCTIONS:

THERAPY ADMINISTRATION

☑ Entyvio Intravenous Infusion

Dose: 300mg in 250mL 0.9% Sodium Chloride

Frequency:

☐ Initial Dose: At week 0, 2, 6, then ☐ q 8 weeks

☐ Maintenance: Every 8 weeks

☐ Other: ____________

☑ Route: IV

☑ Flush with 30ml 0.9% Sodium Chloride at infusion completion

☐ 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, I4H is authorized to administer a generic or biosimilar.

Provider Name (Print) ____________ Provider Signature ____________ Date ____________

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