PRESCRIPTION ORDER FORM

ENTYVIO

(vedolizumab)

Suite Life
Infusing health and wellness into your life.
215 Pleasant Street, 5th Floor, Fall River, MA 02721
Phone: (508) 567-5666 | Fax: (508) 567-5614

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- Tried/Failed Therapies
- Negative TB Results

PRIMARY DIAGNOSIS

☐ K50.00 Crohn's disease of small intestine without complications
☐ K50.10 Crohn's disease of large intestine without complications
☐ K50.90 Crohn's disease, unspecified without complications
☐ K51.00 Ulcerative (chronic) pancolitis without complications
☐ K51.90 Ulcerative colitis, unspecified without complications
☐ Other:_____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

☐ CBC w/ diff & ANC: _____ ☐ LFT's at month 2 then every 3 months after ☐ Other: _____

PRE-MEDICATIONS (15 - 20 MINS BEFORE INFUSION)

☐ Diphenhydramine 25mg PO or IVP & 50mg PO or IVP ☐ Cetrizine 10mg PO ☐ Pepcid 20mg PO or IVP
☐Solu-Medrol 40mg IVP ☐ Solu-Cortef 125mg IVP ☐ Tylenol 650mg PO Other: _____

PRIMARY MEDICATION ORDER

☐ Entyvio 300mg IV at weeks 0, 2, 6, and every 8 weeks thereafter
☐ Entyvio 300mg IV every _____ weeks
☐ Other:_____

*If using SubQ maintenance dosing (must have received 2 IV doses to be eligible):
☐ Infusion clinic to coordinate: Entyvio 108mg SubQ every 2 weeks
☐ Provider to coordinate

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

Provider Signature _____ Date _____