

PRESCRIPTION ORDER FORM

ENTYVIO

(vedolizumab)



Central Fax: 800-504-0870

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

CLINICAL MONITORING: recommended labs to be maintained by ordering provider

- LFT's periodically to be maintained by ordering provider.

PRIMARY MEDICATION ORDER: If necessary, Suite Life will round dose up/down according to payor guidelines

- ☐ 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

REV: 2/26