Checklist for Entyvio (vedolizumab) Referral

Patient Name: ________________________________ **DOB:** ________________ **Date:** ____________________

Referring Physician: _______________________________________ **NPI:** __________________________________

Referring Office Contact/Title: ____

Office Address: ____

Office Phone: ______________________________ **Office Fax:** ______________________________

Best contact number for physician in case of reaction: ____

Please return completed checklist and checklist items to initiate referral. Use this form as fax cover sheet.

- ❑ Patient demographic information
- ❑ Insurance information and copy of insurance card/s (front and back). *Include primary and secondary insurance
- ❑ Supporting clinical notes and office visits. Two notes preferred.
  - Note should include any therapies tried/failed, and must include discussion about Entyvio
  - Medication list and allergies
- ❑ Supporting lab reports/orders for Entyvio treatment
  - *Recommended*: baseline LFTs and LFT continued monitoring q6months during treatment
  - *Recommended*: negative TB screening
- ❑ Entyvio Prescribing Order (see attached)

-- We will obtain prior authorization and schedule your patient as soon as possible –

Fax all information to our Infusion Coordinator: 508-698-8671

Call with any questions: 781-551-5812 ext. 112

Visit our website: www.InfusionCenterNE.com
Email: info@infusioncenterne.com

Infusion Center of New England
9 Payson Road, Suite 100, Foxboro MA 02035
Ph: 781-551-5812
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Prescribing Order: Entyvio (vedolizumab)

Date of Order: ______________________ ❑ New Start ❑ Maintenance
Date of last infusion: _____________

Patient Name: ____ **DOB:** _______________________ **M/F:** ____

Diagnosis (include ICD-10 code/s):____

❑ **NKDA** **Allergies:** ____

Patient Weight: ______________________

Premedication:

❑ Acetaminophen 1000mg PO
❑ Loratadine 10mg or Cetirizine 10mg PO
❑ Diphenhydramine 25mg PO
❑ Diphenhydramine 25mg IV
❑ Solu-medrol 125mg IV
❑ Other: ________________________________

Lab Orders:

❑ CBC w/diff, CMP every ______ weeks
❑ LFTs every ______ weeks
❑ Other: ____

Entyvio Medication Order

Dosing: ❑ Entyvio (vedolizumab) 300mg IV

Frequency: ❑ Dose at week 0, 2, and 6 ❑ Maintenance dose every _______ weeks

Administration:

- ✓ Reconstitute Entyvio with sterile water and dilute in 250ml Normal Saline. Administer intravenously over 30 min
- ✓ Do not administer if patient has active signs or symptoms of infection.
- ✓ Do not administer if patient has new or worsening neurological signs and symptoms.
- ✓ In case of infusion reaction, STOP infusion and follow ICNE infusion reaction protocol. Notify physician.

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Ordering Provider Name **NPI**

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Signature **Date**

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