# INFUSION CENTER OF NEW ENGLAND

## 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 –**

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

Call with any questions: 781-551-5812 option 4

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

**Infusion Center of New England**
18 Washington Street, Foxboro MA 02035
Ph: 781-551-5812
Fax: 508-698-8671

# 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.

**Ordering Provider Name** **NPI**

**Signature** **Date**

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