Entyvio Referral Form®

Phone: 1-800-277-7302 Fax: 1-866-374-6663 Email: intake@healthcoga.com ***Initial order ☐ Reorder ☐***

Demographics Information: Today's Date _____

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: GA Zip: _____

Phone #: _____ ☐ Cell Alternate Phone #: _____ ☐ Cell

Height:_____ in/ft Weight: _____ lbs/kg Date weight recorded: _____ Last 4 of SSN: _____

Allergies: _____ ☐ **NKDA**

Diagnosis Information: ☐ Crohn's of small intestine w/o complications K50.00 ☐ Crohn's disease of large intestine without complications K50.10 ☐ Crohn's of small and large intestine without complications K50.80 ☐ Ulcerative Colitis without complications K51.90 ☐ Other Diagnosis/ICD10Code_____

Date Infusion to Begin: _____

Previous Infusion Reaction: ☐ YES ☐ NO

List Reactions: _____

Is this a first infusion? ☐ YES ☐ NO

Date of Last Infusion: _____

List of Failed Therapies: _____

Assessment Questions: *Please Provide Appropriate Documentation*

Diabetes? ☐ Yes ☐ No HTN? ☐ Yes ☐ No Cardiac History? ☐ Yes ☐ No Difficulty Breathing? ☐ Yes ☐ No
Requires Oxygen? ☐ Yes ☐ No Confusion /Disorientation? ☐ Yes ☐ No Neuro History? ☐ Yes ☐ No
Date of Negative TB test: _____

Entyvio® (Vedolizumab): J3380

☐ **Initial Dose**:300mg IV over 30 minutes at 0, 2, and 6 weeks then every 8 weeks for ☐ 12 months or_____ months

☐ **Maintenance dose**: 300mg IV over 30 minutes every _____weeks for ☐ 12 months or _____ months

Has your patient registered at Entyvio Connect? ☐ Yes ☐ No **If not, please have them to prior to referral*

Pre-Medications: Patient to Provide and take 30 minutes prior to infusion. *Will receive 50 ml of 50ml bag of NS post- infusion*.

☐Acetaminophen 325 mg PO x1 ☐Acetaminophen 650 mg PO x1
☐ Benadryl 50mg PO X1 ☐ Benadryl 25 mg Po x1
☐ Other Pre-medication: _____

Access: ☐ PIV ☐ PORT ☐PICC Route: ☐ IV

Catheter Care/Flush: To gain access, use for any ordered pre-medications, and/or PRN to maintain access and patency

PIV – NS 5ml: Qty 3

PORT – NS 10ml: Qty 3, Heparin 5mL 100units/mL x 1 per infusion.

PICC – NS 10ml:Qty 3, Heparin 5mL 10units/mL x 1 per infusion

Supplies: (please strike through if not required)

Administration Supplies (A4222) – 1 per infusion
Catheter Care Supplies (A4221) – 1 per week
Infusion Pump (E0781)
Nursing services to administer medications

Administer the anaphylaxis protocol for adverse reactions

Provider signature: _____

NPI # _____ Phone _____ Fax _____

Office Address: _____ City: _____ St ____Zip: _____

Printed MD Name:_____ Contact Name: _____

☐ Demographic information ☐ Patient Ins. Card ☐ H & P ☐ Office notes ☐ Failed therapies in documentation
☐ Up to date medication list

9/23 TSP