HOME INFUSION OPTIONS PH:800.996.0978 | FX: 800.430.2202

Crohn's Disease / Ulcerative Colitis

Patient Name:____

DOB: ____________ Phone:______________________________

*** Include a facesheet with demographics and insurance information ***

DIAGNOSIS: ____________________________ ICD-10: ____________

*** Include an H&P, clinical notes and recent labs to support diagnosis ***

Clinical Assessment

Patient is new to therapy Week 0,2,6 and every 8 weeks thereafter

Patient is currently on Therapy

Start Date:____________

Last Infusion Date: __________

Current Weight: __________ kg lb

TB Test Results and Date: ____________

Hep B Test Results and Date: ____________

Other therapies Tried and Failed (Please list):

____

____

Unresponsive to Conventional Treatment

Inadequate Response to Methotrexate (Dose:________)

Requested labs and Frequency Order:

____

____

No labs ordered

Prescription Information

ENTYVIO (vedolizumab) ***300 mg vial***

________ DOSE

________ FREQUENCY

________ REFILLS

REMICADE **INFLECTRA** **May Substitute Biosimilar**

________ mg/kg *weight based*

________ mg *flat-dose*

________ FREQUENCY

________ REFILLS

SKILLED NURSING - PER ADMINISTRATION

PRE-MEDICATION - 30 min prior to administration

Acetaminophen (Tylenol) ______ mg

Diphenhydramine ______ mg PO IVP

Solu-Medrol ______ mg IVP

Other: ______________________

Allergies:____

Infusion supplies and Ambulatory Infusion Pump (E0780) are authorized to be dispensed per pharmacy protocol and medication administration guidelines. Hypersensitivity / Anaphylaxis Reaction per pharmacy protocol (reverse)

ORDERING PROVIDER

Signature:______________________________ Date: ____________

Provider: ______________________________ NPI: ____________

Phone: ______________________ Fax: ________________