INTRAMED Plus
infusion services

ENTYVIO®

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: _____Crohn's Disease ICD-10 Code: K50. _____

_____Ulcerative Colitis ICD-10 Code: K51. _____

_____Other: ICD-10 Code: _____

Allergies:_____(or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical notes, labs, test supporting primary diagnosis
- Previous Drug Therapy History, including therapies trialed and or failed and date of last infusion:

❑ Remicade ❑ Orencia ❑ Humira ❑ Cimzia Date:_____

- TB Screening Documentation

Date of most recent screening:_____

Patient Weight: _____ lbs.

Height: _____ in.

Infusion Center – Lab Orders (Check order for Infusion Center to manage):

❑ Obtain liver enzymes at baseline and every six months thereafter

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ENTYVIO® (vedolizumab) J Code: J3380

4. Drug Order:

Entyvio 300 mg over thirty (30) minutes via a pump.

Frequency: Doses Authorized: 8 doses

❑ New Start: Administer on week 0, 2, 6 and then every 8 weeks thereafter

❑ Maintenance: Administer every eight weeks

❑ Maintenace: Administer every _____ weeks

Pre-Medication Orders: Acetaminophen 650 mg PO administered 30 min prior to infusion *adjust to patient's needs

❑ Other: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____

Dispense as written Substitution permitted

Printed Physician's Name:_____Contact Phone #: _____

FAX ALL INFORMATION	CENTRAL INTAKE PHONE
CENTRAL FAX **803.999.1754**	**803.999.1750**