

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 ICD-10 Code):

Primary Diagnosis: _____ Crohn's Disease (CD) ICD-10 Code: K50: _____
 _____ Ulcerative Colitis (UD) ICD-10 Code: K51: _____
 _____ Other _____ ICD-10 Code: _____
 Allergies: _____ (or attach list)

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

- Clinical documentation supporting primary diagnosis
- Recent Lab/Test Results including:
 - o Tuberculosis (TB) screening results
- Medication List

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|---------------------------|
| Patient |
| Weight: _____ lbs. |
| Height: _____ in. |

4. Drug Order: ENTYVIO® (vedolizumab)

IV Dosing (J3380)

- New Start:** Infuse 300 mg IV at week 0, 2, 6 and then every 8 weeks thereafter. **Doses authorized: 8**
Maintenance: *refill as directed x 1 year
 IV: Infuse 300 mg IV once every 8 weeks.
 IV: Infuse 300 mg IV once every ___ weeks.

SubQ Dosing: switching from IV to SubQ, maintenance dose to start at week 6 or after 2 or more IV infusions

- New Start:** Infuse 300 mg IV at week 0 and 2 **Doses authorized: 2**
Maintenance:
 SUBQ: Inject 108 mg once every 2 weeks. **Doses authorized: 26**

Pre-Medication Orders: _____

No Pre-medications are recommended based on manufacturer guidelines.

Lab Orders: Infusion center to obtain liver enzymes at baseline and every six months thereafter (for IV doses)

Skilled nurse to administer doses by the ordered route (IV or SUBQ). For SUBQ administration, nurse to assess, administer, and/or teach self-administration where appropriate, and provide ongoing support as needed.

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

Anaphylaxis Kit:

- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

By signing this form and utilizing our 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 with Credentials: _____ Phone #: _____

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|---|--|--|
| FAX ALL INFORMATION CENTRAL FAX 803.999.1754 | CENTRAL INTAKE PHONE 803.999.1750 |  <p>Access Intramed Plus prescription order forms here.</p> |
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