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 MD 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: _______ # Refills (Recommend 5 refills)

❑ New Start: Administer on week 0, 2, 6 and then every 8 weeks thereafter
❑ Maintenance: Administer every eight 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 FAX 803.999.1754** **ALTERNATE FAX 803.999.1887**	**INFUSION CENTER LOCATIONS** **COLUMBIA CHARLESTON GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1960**

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