Outpatient Infusion Center
Entyvio Order

Please fax form to: 580-585-5472

Patient Information

Patient Name: DOB: Phone: Gender: M F

Patient Address: Email: Insurance:

Additional Information Needed

- Fax front/back of insurance card
- Fax patient demographics
- Fax clinical/progress notes
- Fax current medication list
- Fax labs
- Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

- K50.10 Crohn's Disease of Large Intestine without complications
- K50.90 Crohn's Disease, Unspecified, without complications
- K51.00 Ulcerative Chronic Pancolitis without complications
- K51.90 Ulcerative Colitis, unspecified without complications
- Other: DX: ____________________

Clinical Information:

New Therapy Induction   Therapy Change   Therapy Continuation

Patient Weight:________ lbs/ ________ kg   Patient Height: ________ in/________ cm

Allergies:____________________

Therapies Tried and Failed: ____________________

TB Test: Date: __________ Results: __________   Hep B Test: Date:__________ Results:__________

Does the patient have venous access? Yes or No   If yes, What type? __________

If No, initiate IV access.

Lab Orders

CBC w/o diff   CMP   ESR   CRP   HBsAg   HBsAB   HBcAB   Quantiferon Gold

Other: ____________________

Lab Orders to be done by

- Infusion Services
- Referring Provider

Prescription Information

Entyvio

Initial Dose: 300mg beginning week, 2 weeks and 6 weeks
Maintenance Dose: 300mg every 8 weeks after week 6

Misc Orders

- ☐ ____________________
- ☐ ____________________

PICC/Midline/CAD dressing to be changed every 7 days

Flushes

- 10mL NS Flush Syringe PRN
- Heparin 500units/5mL Flush Syringe PRN
- 50ml NS Bag PRN
- 250ml NS Bag PRN

Standing Orders for Adverse Reaction

- Stop infusion and initiate NS bolus
- Notify Supervising physician and ordering provider
- Solu-Cortef 100mg SIVP signs of adverse reaction
- Benadryl 25 mg SIVP for hives or bronchial inflammation
- Epi 1:1000 1mL IM, IV or SQ for anaphylaxis
- Oxygen 2-5L nasal cannula
- Albuterol 2.5mg inhaled PRN to chest tightness
- Other: ____________________

Prescriber Information

Physician Name: ____________________   Official Contact Name: ____________________

Contact #: ____________________   Fax Number: ____________________

Address: ____________________   City/State/Zip: ____________________

NPI#: __________ DEA#: __________   State License #: ____________________

____________________ Physician's Signature   ____________________ Date   Time