Comanche County Memorial Hospital

Outpatient Infusion Center
Entyvio Order

Please fax form to: 580-585-5472

PATIENT DEMOGRAPHICS:

PATIENT NAME: _____	**PATIENT'S CONTACT #:** _____
DATE OF REFERRAL: _____	**ADDRESS:** _____
DATE OF BIRTH: _____	**CITY, STATE, ZIP:** _____
INSURANCE: _____	
HEIGHT: _____ **INCHES** **WEIGHT:** _____ **KG**	**GENDER:** **FEMALE** ☐ **MALE** ☐
ALLERGIES: ☐ **NKDA** _____	

PRIMARY DIAGNOSIS:

☐ **K51.00 Ulcerative (chronic) pancolitis without complications**	☐ **K51.20 Ulcerative (chronic) proctitis without complications**
☐ **K51.30 Ulcerative (chronic) rectosigmoiditis without complications**	☐ **K51.50 Left sided colitis without complications**
☐ **K51.80 Other ulcerative colitis without complications**	☐ **K51.90 Ulcerative colitis, unspecified, without complications**
☐ **K50.00 Crohn's disease of small intestine without complications**	☐ **K50.10 Crohn's disease of large intestine without complications**
☐ **K50.80 Crohn's disease of both small and large intestine without complications**	☐ **K50.90 Crohn's disease, unspecified, without complications**
☐ **Other:** _____	

REQUIRED DOCUMENTATION: Please provide a copy of the following documents.

☐ **1. INSURANCE CARD (Front & Back)** ☐ **2. PATIENT DEMOGRAPHICS** ☐ **3. MOST RECENT LABS** ☐ **4. MEDICATION LIST**
☐ **5. H & P** ☐ **6. TRIED/FAILED THERAPIES** ☐ **7. NEGATIVE TB TEST RESULT**

PRIMARY MEDICATION ORDER:

Please include MEDICATION, DOSE, FREQUENCY, DURATION and any ADDITIONAL administration INSTRUCTIONS specific to the primary therapy.

☐ **Entyvio 300mg IV at weeks 0, 2, 6 and every 8 weeks thereafter.**

☐ **Entyvio 300mg IV every_____ weeks.**

☐ **Other:** _____

_____

_____

First Dose: ☐ **Y** ☐ **N**

☐ Refill x 6 months unless otherwise noted.

☐ Biosimilar may be used according to payer guidelines, unless otherwise noted

PRN & PREMEDICATIONS:

MEDICATIONS	30 minutes prior to every infusion	PRN
Acetaminophen 650 mg PO	☐	**PRN every _____ hour for mild or moderate infusion reaction**
Diphenhydramine 25 mg PO	☐	**PRN every _____ hour for mild or moderate infusion reaction**
Diphenhydramine 25 mg IV	☐	**PRN every _____ hour for mild or moderate infusion reaction**
Methylprednisolone 125 mg IV	☐	**PRN every _____ hour for mild or moderate infusion reaction**
Other: _____ _____	☐	**PRN every _____ hour for mild or moderate infusion reaction**

LINE USE/CARE ORDERS:

☐ **START PIV/ACCESS CVC**
☐ **FLUSH DEVICE PER CCMH INFUSION POLICY & PROCEDURE**
☐ **OTHER FLUSH ORDERS:** **(please fax other line care orders if checking this box)**

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

☐ **ADMINISTER ACUTE INFUSION AND ANAPHYLAXIS MEDICATIONS PER CCMH INFUSION POLICY AND PROCEDURE**
☐ **OTHER FLUSH ORDERS:** **(please fax other reaction orders if checking this box)**

PRESCRIBER INFORMATION: Please check preferred form of communication.

PROVIDER NAME: _____	**PHONE:** _____
OFFICE CONTACT: _____	☐ **FAX:** _____
ADDRESS: _____	☐ **EMAIL:** _____
CITY, STATE, ZIP: _____	**NPI:** _____

→ **(DISPENSE AS WRITTEN)**

_____ _____
Provider Signature Date/Time