CoxHealth at Home

CoxHealth

ENTYVIO ®

(vedolizumab)

Phone: 1-855-419-4663

Fax: 1-417-269-0692

Patient Information

Name:_____ DOB:_____

Height: _____ ❑ in ❑ cm Weight_____ ❑ kg ❑ lbs

Address:_____

_____

City:_____ State:_____ Zip:_____

Phone:_____ Alternate:_____

SSN:_____

PLEASE INCLUDE ON FAX A COPY OF FRONT AND BACK OF INSURANCE CARD(S)

Prescriber

Prescriber name:_____

NPI: _____

Address:_____

_____

City:_____ State:_____ Zip:_____

Contact:_____

Phone:_____ Fax:_____

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ❑ K50.90 (Crohn's disease) ❑ K51.0 (Ulcerative colitis)

❑ Other: _____

Allergies:_____

Intravenous ENTYVIO®

Flushing/Premedication Orders:

✓ Flushing per CoxHealth at Home protocol

- ✓ PIV: 0.9% sodium chloride 3-20mL before and after infusion as needed
- ✓ Port: 0.9% sodium chloride 3-20mL into port at time of access or at least monthly, 0.9% sodium chloride 3-20mL before and after infusion as needed, Heparin 100 units/mL 5mL as lock after infusion
- ✓ Following infusion, flush line with 30mL of 0.9% sodium chloride

✓ No routine premedication necessary. If desired, please write here: _____

ENTYVIO® (vedolizumab) IV over 30 minutes

Frequency:

❑ Loading Frequency: 3 doses at weeks 0,2 and 6 followed by infusions every 8 weeks thereafter

OR

❑ Maintenance frequency: every 8 weeks

OR

❑ Other frequency:_____

Dose: 300mg dilute in 250mL 0.9% sodium chloride

Quantity to dispense: ❑ 1 dose with 9 refills (1 year) or ❑ _____infusion(s)

Labs: every _____ (frequency) ❑ CBC with diff ❑ CMP ❑ Other:_____

Prescriber's Signature:_____ Date_____

I authorize CoxHealth at Home and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to CoxHealth at Home.