Entyvio (vedolizumab)

Provider Order Form *rev. 1/5/2025*

AMERICAN INFUSION CARE
SPECIALTY INFUSION

PATIENT INFORMATION

Referral Status: ☑ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

Ulcerative Colitis

- ☐ 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

Crohn's Disease

- ☐ 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 include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.
Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

- ☐ Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mgPO
- ☐ Cetirizine (Zyrtec) 10mgPO
- ☐ Loratadine (Claritin) 10mgPO
- ☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
- ☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV
- ☐ Other: _____ Dose: _____ Route: _____

Lab Orders

Required: Negative TB results
☐ Other: _____

Entyvio (vedolizumab) (Select one):

☐ **Option 1:** Infuse 300 mg IV over at least 30 minutes on weeks 0, 2, 6 (2 IV doses)
Maintenance: every 8 weeks thereafter ☐ every_____weeks

☐ **Option 2:** Infuse 300 mg IV over at least 30 minutes on weeks 0, 2 (2 IV doses)
Maintenance: Inject Entyvio 108 mg SubQ at week 6, then every 2 weeks thereafter (2 SC doses)

☐ **Other:** _____

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

Special Instructions: _____

☐ **Refills:** ☐ zero ☐ 6 months ☐ 12 months ☐ _____ *(Prescription valid for one year, unless otherwise indicated)*

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

Provider Name (Print) *Provider Signature* *Date*

E: Referrals@americaninfusioncare.com
Americaninfusioncare.com

Greater Houston Area F: 832.510.7824 P: 832.800.3213
McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454
Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213
Other Locations (Oaklawn, Lancaster, etc): F: 469.305.2361 P: 972.865.4454