Infusion ASSOCIATES®

Phone: (833) 394-0600 Fax: (833) 996-4888

Entyvio IV Infusion

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications and **Recent Visit Notes***

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

ICD-10 : _____, _____, _____

If patient is under 18 years of age, please send letter of medical necessity

In the past year, what medications for the above diagnosis has the patient tried and failed?

Drug	Dose	Dates of use

Labs to be collected: ☐BMP ☐CMP ☐CBC w/o diff ☐CBC w/diff ☐CBC w/man diff ☐CRP ☐ESR ☐ _____

Lab Frequency: ☐ EVERY infusion ☐ Every OTHER infusion ☐ Other:_____

Pre-Medications:	**Diphenhydramine PO**	25mg or 50mg	☐Yes ☐ No
	Cetirizine PO	10mg	☐Yes ☐ No
	Acetaminophen PO	650mg	☐Yes ☐ No

Entyvio 300mg (vedolizumab) IV

Frequency: ☐ Initial Dose – 0, 2, 6wks THEN q 8 wks.

Maintenance dosing: ☐ q 8 weeks ☐ q _____weeks

If dosing ordered other than q8weeks, please provide letter of medical necessity

Date of last infusion if not at IA:_____ **Expiration Date:** _____/_____/_____

Printed Provider Name: _____

Provider Signature: _____

Office Phone Number: _____**Office Fax Number:** _____

Contact Name: _____**Contact Phone Number:** _____

New referring providers, how did you hear about us? ☐Web Search ☐Pharma Rep ☐Drug Locator ☐Patient ☐Word of Mouth ☐IA Clinical Liaison ☐IA Website ☐Facebook ☐Instagram ☐TV/streaming ☐ Other: _____