FLOMED INFUSION

6274 Linton Blvd. Suite 105 | Delray Beach, FL 33484
T: 561-559-9800 F: 561-559-9801
flomedinfusion.com

ENTYVIO (vedolizumab)

PATIENT INFORMATION

Patient Name:______________________ Date of Birth: ____________ Phone: ____________

Status: ☐ New to therapy ☐ Continuing ☐ Next Due Date (if applicable)

PROVIDER INFORMATION

Provider Name:______________________ Provider NPI: ____________

Practice Address: ______________________ City: ____________ State: ________ Zip: ________

Practice Name: ______________________

Practice Phone: ____________ Fax: ____________ Contact Person: ____________

MEDICAL INFORMATION

Patient Weight: ________ Patient Height: ________ ICD-10 Code (required): ____________ ICD-10 Description: ____________

Known Allergies: ______________________

Required Labs: Baseline Liver Enzymes, within the last 6 months.

DETAILS NEEDED FOR AUTHORIZATION

- Proof of patient being concurrently treated with any other biologic: ____________
- TB Protocol: Baseline testing: Quantiferon Gold or PPD
- Annual TB screening (optional)

ENTYVIO (vedolizumab) ORDERS

Initial Dose: ☐ 300 mg/kg IV at 0, 2, 6 and then every 8 weeks

Maintenance Dose: ☐ 300 mg/kg every 8 weeks

Other Dose: ☐ ____________ mg/kg every ________weeks

Additional Orders/Comments: ______________________

____

____

____

ADULT RESCUE MANAGEMENT PROTOCOL

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Following standing reaction orders, including diphenhydramine, methylprednisolone, albuterol, and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

REQUIRED STANDARD DOCUMENTATION NEEDED

- Patient demographics
- Patient medical insurance card, copied front and back
- Patient pharmacy card, copied front and back (if they have one)
- Most recent chart notes and if available, last history and physical. All relevant scans, tests and laboratory results.
- If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.

PROVIDER AUTHORIZATION

Provider's Signature: ______________________ Print Name: ____________ Date: ____________