MATAGORDA REGIONAL
MEDICAL CENTER
MRMC IV THERAPY SERVICES
PHONE: 979-241-5966
FAX: 979-241-5965

ENTYVIO (VEDOLIZUMAB) ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ WT: _____ Sex :( ) Male ( ) Female SSN:_____ Home #:_____ Cell#:_____

Street Address_____ City/State/Zip _____

Allergies:_____

INSURANCE INFORMATION

Primary Insurance Name _____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

PHYSICIAN / FACILITY INFORMATION

Physician Name_____ Contact Name _____ Contact Phone # _____

Address: _____City/State/Zip_____

DEA#:_____ NPI #:_____ State Lic #:_____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: ICD-10 Code plus Description:_____

PERTINENT MEDICAL HISTORY **1)** TB test performed? O Yes O No Results,_____

2) Patient diagnosed with Congestive Heart Failure? O Yes O No **3)** Liver function test normal? O Yes O No

4) Patient previously treated with Entyvio? O Yes O No Date: _____ 5) Hep-B antigen surface antibody test? O Yes O No Date: _____

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL
b) ADMINISTER CATH-FLO 2MG, IVP PER PORT IF PICC LINE IS SLUGGISH OR OCCLUDED, MAY REPEAT AFTER 2 HRS IF NEEDED X 1.
c) ENTYVIO (VEDOLIZUMAB) WILL BE ADMINISTERED IN NS 0.9% 250 ML OVER NO LESS THAN 30 MINUTES WITH A 1.2 MICRON FLITER
d) ALL LINES WILL BE FLUSHED WITH 30 ML OF 0.9% NS UPON COMPLETION OF INFUSION

PRESCRIPTION ORDERS: ENTYVIO (VEDOLIZUMAB)

Does patient have venous access? ☐ **YES** ☐ **NO**

If yes, what type: ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

SELECT BELOW	DOSING OPTIONS	DOSE	ROUTE	FREQUENCY (POPULATE BELOW)	DURATION
	LOADING DOSES	300 MG	IV	0, 2, 6 WEEKS, THEN ONCE EVERY WEEKS	
	MAINTENANCE DOSE	300 MG	IV	ONCE EVERY WEEKS	

PREMEDS

SELECT BELOW	MEDICATION	DOSE	ROUTE
	BENADRYL, PRN		
	ACETAMINOPHEN, PRN		
	OXYGEN		
	Other:		
	Other:		
	Other:		

LABS

SELECT BELOW	LAB REQUESTED	WHEN	FREQUENCY
	BMP	( ) PRIOR ( ) POST	
	CMP	( ) PRIOR ( ) POST	
	BUN/CREATININE	( ) PRIOR ( ) POST	
	CRP:	( ) PRIOR ( ) POST	
	ESR:	( ) PRIOR ( ) POST	
	Other:	( ) PRIOR ( ) POST	

NOTES/INSTRUCTIONS/COMMENTS

_____

_____

FLUSHES: ☐ 10 mL NS Flush Syringe PRN ☐ Heparin 500 units/5 mL Flush Syringe PRN ☐ NS 50 mL PRN

Physician's Signature _____ **Time** _____ **Date**_____

Fax completed form to the MRMC Infusion Center at 979-241-5965.
PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, and CURRENT INSURANCE INFORMATION in order for your referral to be processed.