BARNES HEALTHCARE SERVICES

Entyvio® (vedolizumab) Order Form

Please fax all pages of completed form to our Intake team at 888.276.7948
Contact our Intake team 800.422.5059 ext.1480

1 Patient Information — Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient

Patient's first name _____ **Last name** _____ **MI** _____

Preferred patient first name _____ **Preferred patient last name** _____

Sex at birth: ☐ Male ☐ Female **Gender identity** _____ **Pronouns** _____

Last 4 of SSN _____ **Date of birth** _____/_____/_____

Street address _____ **Apt #** _____

City _____ **State** _____ **Zip** _____

Home phone _____ **Cell phone** _____ **Email address** _____

Parent/guardian (if applicable)

Home phone _____ **Cell phone** _____ **Email address** _____

Alternate caregiver/contact

Home phone _____ **Cell phone** _____ **Email address** _____

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other **If other, please specify** _____

Provider will read the following statement to patient: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Barnes Healthcare Services about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

2 Prescriber Information — All fields must be completed to expedite prescription fulfillment.

Date _____ **Time** _____ **Date medication needed** _____/_____/_____

Office/clinic/institution name

Prescriber's first name _____ **Last name** _____

Prescriber's title _____ **If NP or PA, under direction of Dr.** _____

Office phone _____ **Fax** _____ **NPI #** _____ **License #** _____

Office contact and title _____ **Office contact email** _____

Office street address _____ **Suite #** _____

City _____ **State** _____ **Zip** _____

Infusion location: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site

If infusion site, complete information below:

Infusion site name _____ **Clinic/hospital affiliation** _____

Site street address _____ **Suite #** _____

City _____ **State** _____ **Zip** _____

Infusion site contact _____ **Phone** _____ **Fax**

Email _____

Note: Check the appropriate shipment options in Section 4: Prescribing Information.

3 Clinical Information

Primary ICD-10 code (REQUIRED):_____

Has the patient been treated previously for this condition? ☐ Yes ☐ No

Is patient currently on therapy? ☐ Yes ☐ No

Please list all therapies tried/failed: _____

Patient wt _____ **Date wt obtained:** _____/_____/_____

☐ NKDA **Known drug allergies** _____

Concurrent meds: _____

4 Prescribing Information

INFUSION LOCATION: ☐ Patient's home ☐ Healthcare facility

Medication	Strength / Formulation	Directions	Quantity / Refills
Entyvio® (vedolizumab) — IV Loading and Maintenance			
Entyvio® (vedolizumab)	300mg single dose vial	For patients on Intravenous infusion for Loading and Maintenance dose Loading dose: Infuse 300mg IV at week 0, 2, 6 and then every 8 weeks thereafter. Maintenance dose: Infuse 300mg IV every 8 weeks.	Loading dose: QS for 3 doses · No refills Maintenance dose: 8-week supply · Refill x 1 year unless noted otherwise. ____ week supply ____ Refills
— OR —			
Entyvio® (vedolizumab)	300mg single dose vial (loading) 108mg/0.68mL Single-dose pen (maintenance)	For patients switching from Intravenous to subcutaneous; maintenance dose to start at week 6 or after 2 or more IV infusions. Loading dose: Infuse 300mg IV at week 0, 2 and then inject 108mg SC every 2 weeks starting week 6. Maintenance dose: Inject 108mg SC every 2 weeks.	Loading dose: QS for 2 doses · No refills ☐ 1-month supply ☐ 3-month supply ☐ Other _____ ____ Refills

Required medication and supplies for home infusion (please complete this section for home infusions only)

Premedication orders:

☐ Acetaminophen 650mg PO 30 min prior to infusion

☐ Diphenhydramine 50mg PO 30 min prior to infusion

☐ Other _____

Infusion method: ☐ Gravity (Pediatric patients will be given a pump unless noted otherwise)

Fluids for administration and reconstitution (please strike through if not required)

Fluid options should be as follows:

☐ NS 0.9% 250mL

☐ Sterile Water as needed for reconstitution

☐ NS 0.9% 50mL. Use 30mL for post infusion flush

☐ NS 0.9% Flush (if central venous access, sterile flush will be provided)

Choose administration access: ☐ Peripheral access ☐ Central venous access

If central venous access:

☐ Flush with 10mL Sterile NS 0.9% before and after infusion

☐ Follow with heparin 100 units/mL 5mL final flush

If peripheral access:

☐ Flush with 3mL NS 0.9% before and after infusion and as needed

Hypersensitivity / Anaphylaxis:

☐ Stop infusion

Medicate with:

☐ Epinephrine / EpiPen 0.3mg IM as needed for anaphylaxis (for children less than 30kg: Epinephrine 0.15mg)

☐ Start NS 0.9% 100mL at TKO

☐ Diphenhydramine 50mg slow IVP PRN anaphylaxis

☐ Hydrocortisone 100mg slow IVP PRN anaphylaxis

☐ Solu-Medrol 125mg slow IVP PRN anaphylaxis

☐ Diphenhydramine 50mg PO PRN anaphylaxis

☐ Other _____

Send quantity and refills sufficient for medication days supply.

Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy.

If nursing services will be required for therapy administration, the home health nurse may call for additional orders per state regulations.

Lab orders CBC/LFT **Frequency** q 6 months

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.

(S9359, S9379)

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE	

Date _____ ☐ **Dispense as written** **Date** _____ ☐ **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.