

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____
 ADDRESS: _____ CITY, STATE, ZIP: _____
 DATE OF BIRTH: _____ EMAIL: _____
 ALLERGIES: SEE LIST NKDA WEIGHT: LB OR KG

REQUIRED DOCUMENTATION

- | | | | | |
|---------------------------|------------------------|-------------------------|---------------------|--------------------|
| 1. Insurance Card | 2. History & Physical | 3. Patient Demographics | 4. Most Recent Labs | 5. Medication List |
| 6. Tried/Failed Therapies | 7. Negative TB Results | | | |

PRIMARY DIAGNOSIS

K50.00 Crohn’s disease of small intestine without complications K50.10 Crohn’s disease of large intestine without complications
 K50.90 Crohn’s disease, unspecified without complications K51.00 Ulcerative (chronic) pancolitis without complications
 K51.90 Ulcerative colitis, unspecified without complications Other _____

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

Per infusion clinic protocol: There are no recommended standard pre-meds for Entyvio
 Provider Prescribed: _____

PRIMARY MEDICATION ORDER

Entyvio 300mg IV at weeks 0, 2, 6, and every 8 weeks thereafter *If using SubQ maintenance dosing (must have received 2 IV doses to be eligible):
 Entyvio 300mg IV every _____ weekss Provider to coordinate
 Other _____
 FIRST DOSE?: Yes No Refill x12 months unless otherwise noted.

LINE USE/CARE ORDERS

Start PIV/ACCESS CVC Flush device per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)
 Other Flush Orders: Please send other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

Administer acute infusion and anaphylaxis medications per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)
 Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____
 OFFICE CONTACT: _____ FAX: _____
 ADDRESS: _____ EMAIL: _____
 CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

X

PROVIDER SIGNATURE _____ DATE _____