TEXASINFUSION

1935 W. State Street STE 103
Garland, TX 75042
Ph: 972-372-7987
Fx: 972-787-1492

ENTYVIO INFUSION REFERRAL FORM

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Patient Weight = _____kg / _____lbs

DIAGNOSIS AND ICD 10 CODE	
☐ Chron's Disease	ICD 10 Code: _____
☐ Ulcerative Colitis	ICD 10 Code: _____
☐ Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Annual TB- Quantiferon TB gold OR neg. chest X-ray
☐ Face sheet and Insurance card	☐ Labs: CBC w/ diff and LFT's
☐ Clinical/Progress notes	☐ Hepatitis B antigen screening

List Tried & Failed Therapies, including duration of treatment:
1)
2)
3)

PA Guidance: Failed Steroids, NSAID, MTX, leflunomide. Failed injectable biologics: Humira, Cimzia, Infliximab, or Stelara.

ORDERS	
Dose: 300mg/250ml 0.9% NS infused IV over 30 min	☐ **Induction** dose Entyvio 300mg at 0, 2, 6 weeks. ☐ **Maintenance** dose Entyvio 300mg IV every 8 weeks (OR every _____ weeks) ☐ Normal saline Flushes 10ml as needed (max 10 per infusion) ☐ PREMEDS: _____
Infusion orders	☐ Nurse to start, pause, or discontinue peripheral or central venus access device PRN ☐ Flush IV line with 10-20ml saline before and after each medication dose or as needed ☐ Flush PORT or Central Line with 500u/5ml Heparin as FINAL flush or as needed ☐ Dispense DME pump with all necessary supplies for home infusion
Anaphylaxis kit per pharmacy protocol (IM .3mg Epinephrine, IV 50mg Diphenhydramine, and IV 1L 0.9% NS)	
Refills: ☐ X 6 months ☐ X 1 year ☐ _____ doses	

PRESCRIBER INFORMATION		
Prescriber Name:	NPI #:	
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

By signing, I authorize Texas Infusion to act as an agent to initiate and execute the insurance authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time in writing via email to pharmacy@texasinfusion.com

PLEASE FAX SIGNED FORM TO 972-787-1492

UPDATED: 1-2-2023