



1935 W. State Street STE 103  
 Garland, TX 75042  
 Ph: 972-372-9787  
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## ENTYVIO INFUSION ORDER FORM

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Weight:                      kg ; Height:                      in

DIAGNOSIS AND ICD 10 CODE	
<input type="checkbox"/> Chron's Disease	ICD 10 Code: _____
<input type="checkbox"/> Ulcerative Colitis	ICD 10 Code: _____
<input type="checkbox"/> Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION	
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Face sheet and Insurance card <input type="checkbox"/> Clinical/Progress notes	<input type="checkbox"/> Annual TB- Quantiferon TB gold OR neg. chest X-ray <input type="checkbox"/> Labs: CBC w/ diff and LFT's <input type="checkbox"/> Hepatitis B antigen screening
List Tried & Failed Therapies, including duration of treatment:	
1) 2) 3)	<u>PA Guidance:</u> 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	<input type="checkbox"/> <b>Induction</b> dose Entyvio 300mg at 0, 2, 6 weeks. <input type="checkbox"/> <b>Maintenance</b> dose Entyvio 300mg IV every 8 weeks (OR every _____ weeks) <input checked="" type="checkbox"/> Normal saline Flushes 10ml as needed (max 10 per infusion) <input type="checkbox"/> PREMEDS: _____
Infusion orders	1. Nurse to start, pause, or discontinue peripheral or central venous access device PRN 2. Flush IV line with 10-20ml saline before and after each medication dose or as needed 3. Flush PORT or Central Line with 500u/5ml Heparin as FINAL flush or as needed 4. Dispense DME pump with all necessary supplies for home infusion
Anaphylaxis kit per pharmacy protocol (IM .3mg Epinephrine, IV 50mg Diphenhydramine, and IV 500mL 0.9% NS)	
Refills:	<input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ 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](mailto:pharmacy@texasinfusion.com)

**PLEASE FAX SIGNED FORM TO 972-787-1492**