Beacon Infusion
Healthcare Services

Headquarters Location:
1075 Stephenson Ave, Suite D-2, Oceanport, NJ 07757
Telephone: (833) 223-2266 Fax: (732) 329-2322

ENTYVIO MEDICATION ORDER

Patient's Name (Last, First, Middle) _____ **DOB:** _____

■ **Diagnosis** *Please specify the ICD10 code if using a diagnosis with a ___ noted.*

☐ K50.90 Ulcerative colitis ☐ K50.9_____ Crohn's disease (specific ICD10)

■ **Details Needed for Authorization**

- Proof of patient's negative latent TB test. If test is positive, proof that patient has begun therapy for latent TB.
- Is patient concurrently being treated with any other biologic? _____
- Does the patient have an intolerance, contraindication or hypersensitivity to any of the following agents, or has tried and failed on at least one with at least 3 months of therapy? If yes, circle all that apply. They are: 6-mercaptopurine, aminosalicylates, azathioprine, corticosteroids, mesalamine, methotrexate, sulfasalazine, hydroxychloroquine, Otezla, NSAIDs and leflunomide.
- Please provide documented failure, contraindication, or ineffective response at maximum tolerated doses to a minimum (3) month trial on previous therapy with a TNF modifier such as Humira, Simponi, or infliximab (Avsola, Inflectra, Remicade or Renflexis).

■ **Entyvio (vedolizumab) Medication Order** **Patient's height in ft/in: _____ Patient's weight in lbs: _____**

Select all doses required.

☐ Starting dose: 300mg in 250ml normal saline over about 30 minutes at weeks 0, 2 and 6.

☐ Maintenance dose: 300mg in 250ml normal saline over about 30 minutes every 8 weeks for _____ months.

Post infusion flush with normal saline. Check vitals and monitor for signs and symptoms at start, throughout infusion, and after completion.

■ **Rescue Management in case of Infusion Therapy Reaction**

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Stop medication infusion and start normal saline infusion at 50 ml/hr. Call ordering provider to report reaction.
- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

■ **Ordering Provider Authorization**

Provider's Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone Line to Contact Person: _____

STANDARD DOCUMENTATION TO INCLUDE:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.
- If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.

Fax this order and supporting documentation to (732) 329-2322.