

ENTYVIO REFERRAL FORM

PATIENT DEMOGRAPHICS:

PATIENT NAME:	PATIENT'S CONTACT #:	
DATE OF REFERRAL:	ADDRESS:	
DATE OF BIRTH:	CITY, STATE, ZIP:	
FOR COPAY ASSISTANCE, PLEASE PROVIDE LAST 4 OF SSN:		
HEIGHT: _____ FEET _____ INCHES	GENDER: FEMALE	MALE
WEIGHT: _____ LB or _____ KG	ALLERGIES: SEE LIST	NKDA

PRIMARY DIAGNOSIS:

K51.00 Ulcerative (chronic) pancolitis without complications	K51.20 Ulcerative (chronic) proctitis without complications
K51.30 Ulcerative (chronic) rectosigmoiditis without complications	K51.50 Left sided colitis without complications
K51.80 Other ulcerative colitis without complications	K51.90 Ulcerative colitis, unspecified, without complications
K50.00 Crohn's disease of small intestine without complications	K50.10 Crohn's disease of large intestine without complications
K50.80 Crohn's disease of both small and large intestine without complications	K50.90 Crohn's disease, unspecified, without complications
Other	

REQUIRED DOCUMENTATION: Please provide a copy of the following documents.

<input checked="" type="checkbox"/> 1. INSURANCE CARD (Front & Back)	<input checked="" type="checkbox"/> 2. PATIENT DEMOGRAPHICS	<input checked="" type="checkbox"/> 3. MOST RECENT LABS	<input checked="" type="checkbox"/> 4. MEDICATION LIST
<input checked="" type="checkbox"/> 5. H & P	<input checked="" type="checkbox"/> 6. TRIED/FAILED THERAPIES	<input checked="" type="checkbox"/> 7. NEGATIVE TB TEST RESULT	

PRIMARY MEDICATION ORDER:

PRN & PREMEDICATIONS:

Please include MEDICATION, DOSE, FREQUENCY, DURATION and any ADDITIONAL administration INSTRUCTIONS specific to the primary therapy. Entyvio 300mg IV at weeks 0, 2, 6, and every 8 weeks thereafter. Entyvio 300mg IV every _____ weeks. Other: FIRST DOSE: Y N <input checked="" type="checkbox"/> Refill x12 months unless otherwise noted.	MEDICATIONS	30 minutes prior to every infusion	PRN
	Acetaminophen 650 mg PO		PRN every ___ hour for mild or moderate infusion reaction.
	Diphenhydramine 25 mg PO		PRN every ___ hour for mild or moderate infusion reaction.
	Diphenhydramine 25 mg IV		PRN every ___ hour for mild or moderate infusion reaction.
	Methylprednisolone 125 mg IV		PRN every ___ hour for mild or moderate infusion reaction.
	Other: _____		PRN every ___ hour for mild or moderate infusion reaction.

LINE USE/CARE ORDERS:

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

<input checked="" type="checkbox"/> START PIV/ACCESS CVC <input checked="" type="checkbox"/> FLUSH DEVICE PER FLEXCARE INFUSION POLICY & PROCEDURE (SEE REVERSE SIDE) OTHER FLUSH ORDERS: (please fax other reaction orders if checking this box)	<input checked="" type="checkbox"/> ADMINISTER ACUTE INFUSION AND ANAPHYLAXIS MEDICATIONS PER FLEXCARE INFUSION POLICY AND PROCEDURE (See Reverse Side) OTHER: (please fax other reaction orders if checking this box)
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PRESCRIBER INFORMATION: Please check preferred form of communication.

PHYSICIAN NAME:	PHONE:
OFFICE CONTACT:	FAX:
ADDRESS:	EMAIL:
CITY, STATE, ZIP:	NPI:

 (GENERIC SUBSTITUTION PERMITTED)
 PHYSICIAN SIGNATURE: _____ DATE: _____

 (DISPENSE AS WRITTEN)
 PHYSICIAN SIGNATURE: _____ DATE: _____

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FLEXCARE INFUSION CENTER'S ACUTE & ANAPHYLAXIS MEDICATION PROTOCOL:

**This table does not reflect non-medicinal interventions that are part of FlexCare's protocol, such as slowing or stopping the infusion and physician/911 notification.*

	MILD INFUSION REACTION	MODERATE INFUSION REACTION	SEVERE INFUSION REACTION/ANAPHYLAXIS
SYMPTOM CLASSIFICATION	<ul style="list-style-type: none"> Flushing Dizziness Headache Apprehension Diaphoresis Palpitations Nausea / Vomiting Pruitis 	<ul style="list-style-type: none"> Chest Tightness Shortness of Breath Hypo/hypertension (>20 mmHg Change in Systolic BP from Baseline) Increased Temperature (>2 Degrees Fahrenheit) Urticaria 	<ul style="list-style-type: none"> Hypo/hypertension (>40 mmHg Change in Systolic BP from Baseline). Increase Temperature (>2 Degrees Fahrenheit) with Rigors Shortness of Breath with Wheezing Laryngeal Edema Chest Pain Hypoxemia
TREATMENT PROTOCOL FOR ADULTS >66LBS	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Apply oxygen via ambu bag or high flow nasal canula, if vomiting. <input checked="" type="checkbox"/> Administer 0.9% NaCl 500 mL at 125mL/hr to maintain IV access. <input checked="" type="checkbox"/> Administer diphenhydramine 50 mg IV or IM Inject epinephrine 0.3mg/0.3 mL IM into the midanterolateral aspect of the thigh; repeat in 5-15 minutes if needed. <input checked="" type="checkbox"/> Administer 0.9% NaCl 1000mL bolus for an incomplete response to IM epinephrine. May repeat x1.
TREATMENT PROTOCOL FOR CHILDREN 33LBS - 66 LBS	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Apply oxygen via ambu bag or high flow nasal canula, if vomiting. <input checked="" type="checkbox"/> Administer 0.9% NaCl 500mL at 75mL/hr to maintain IV access. <input checked="" type="checkbox"/> Administer diphenhydramine 1-2 mg/kg IM or slow IVP not to exceed 25mg/min <input checked="" type="checkbox"/> Inject epinephrine 0.15mg/0.15 mL IM into the mid-anterolateral aspect of the thigh; repeat in 5-15 minutes if needed. <input checked="" type="checkbox"/> Administer 0.9% NaCl bolus 20mL/kg for an incomplete response to IM epinephrine. May repeat x1.

FOR CHILDREN < 33 LBS FLEXCARE INFUSION UTILIZES THE REACTION ORDERS OBTAINED BY THE REFERRING PHYSICIAN.

FLUSHING PROTOCOLS

		FLUSHING PROTOCOL Normal Saline*		LOCKING PROTOCOL Heparin Sodium	
		0.9% Sodium Chloride		10 Units/mL	100 Units/mL
PATIENT CLASSIFICATION	LINE TYPE	PRE-ADMIN	POST ADMIN	POST LAB DRAW	POST NS FLUSH*
ADULT > 66 LBS	Peripheral IV Catheter	3 mL	3 mL		3 mL
	Midline	3 mL	3 mL		3 mL
	Implanted Port	5 mL	10 mL	10 mL	5 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	10 mL	10 mL	5 mL
	Tunneled & non-Tunneled Catheters	5 mL	10 mL	10 mL	5 mL
PEDIATRIC 33 LBS - 66 LBS	Peripheral IV Catheter	3 mL	3 mL		3 mL
	Midline	3 mL	3 mL		3 mL
	Implanted Port	5 mL	5 mL	10 mL	3 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	5 mL	10 mL	3 mL
	Tunneled & non-Tunneled Catheters	5 mL	5 mL	10 mL	3 mL

FOR CHILDREN <33 LBS, FLEXCARE INFUSION UTILIZES THE FLUSHING ORDERS OBTAINED BY THE REFERRING PHYSICIAN.

*0.9% NS will be substituted with Dextrose 5% or alternative only when indicated due to medication incompatibility with NS.