Entyvio® Infusion Referral Form

University Hospitals Home Care Services

4510 Richmond Road
Warrensville Heights, OH 44128
Phone: 800-552-8442
Fax: 216-201-5127

Please complete each section of the referral form below and fax along with a copy (front and back) of all of the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents.

Prescriber Info.

Prescriber: _____ **NPI:** _____

Phone: _____ **Fax:** _____ **Office Contact:** _____

Address: _____

_____

Patient Information

Name: _____ **DOB:** _____ ☐ **M** ☐ **F**

Address: _____

Phone: _____ **2nd Phone:** _____ **SSN:** _____

Primary Language: _____ **Functional Limitations:** _____

Clinical Information

Diagnosis (include ICD-10 code): _____

Weight: _____ ☐ lb ☐ kg **Height:** _____ ☐ in

IV access: ☐ PIV ☐ PICC ☐ Port ☐ Other: _____ **Patient's first dose?** ☐ Yes ☐ No (If no, date of last dose: _____)

Allergies: _____ **Latex allergy?** ☐ Yes ☐ No

Prior treatments & reason for discontinuation: _____

_____

Date of *negative* TB test: _____ ☐ TB test pending, will fax results. **Patient is HBV negative or has been treated:** ☐ Yes ☐ No

History of kidney disease: ☐ Yes ☐ No If yes, SCr: _____ GFR/CrCl: _____ **History of heart failure:** ☐ Yes ☐ No

Referring provider's preferred site of care: ☐ Home Care Infusion Center ☐ Home Infusion ☐ Home Care to determine site of care

Site of care preference is subject to payer limitations, clinical appropriateness, and the availability of servicing providers.

Additional Notes: _____

_____

_____

Prescription Information

Dosing Regimen	Quantity
☐ **Induction:** Entyvio® 300mg in 250mL NaCl 0.9% infused weeks 0, 2, and 6. Infuse over approximately 30 minutes. Flush line with 30mL NaCl 0.9% following infusion.	3 doses (infusions)
☐ **Maintenance:** Beginning week 14, infuse Entyvio® 300mg in 250mL NaCl 0.9% every 8 weeks. Infuse over approximately 30 minutes. Flush line with 30mL NaCl 0.9% following infusion.	_____ doses (infusions)

Premedication orders: _____

PRN medication orders: _____

Laboratory orders (subject to availability): _____

_____

Prescriber Signature

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize Home Care and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide infusion-related nursing services and supplies in conjunction with the therapy prescribed above.

Signature: _____ **Date:** _____