

Entyvio® Infusion Referral Form



University Hospitals
Home Care Services

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Warrensville Heights, OH 44128
Phone: 800-552-8442
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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: _____ <input type="checkbox"/> M <input type="checkbox"/> F	
	Address: _____	
	Phone: _____ 2 nd Phone: _____ SSN: _____	
	Primary Language: _____ Functional Limitations: _____	
Clinical Information	Diagnosis (include ICD-10 code): _____	
	Weight: _____ <input type="checkbox"/> lb <input type="checkbox"/> kg Height: _____ <input type="checkbox"/> in	
	IV access: <input type="checkbox"/> PIV <input type="checkbox"/> PICC <input type="checkbox"/> Port <input type="checkbox"/> Other: _____ Patient's first dose? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, date of last dose: _____)	
	Allergies: _____ Latex allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Prior treatments & reason for discontinuation: _____ _____	
	Date of <u>negative</u> TB test: _____ <input type="checkbox"/> TB test pending, will fax results. Patient is HBV negative or has been treated: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	History of kidney disease: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, SCr: _____ GFR/CrCl: _____ History of heart failure: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Referring provider's preferred site of care: <input type="checkbox"/> Home Care Infusion Center <input type="checkbox"/> Home Infusion <input type="checkbox"/> 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
	<input type="checkbox"/> 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)
	<input type="checkbox"/> 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: _____	

Confidentiality statement: This message is intended only for the individual or institution to which it is addressed. This may contain information, which is confidential, privileged, and/or proprietary. This information may be exempt from disclosure under applicable laws including but not limited to HIPAA. If you are not the intended recipient, please note you are strictly prohibited from distributing, copying, or disseminating this information. If you received this information in error, please notify the sender noted above and destroy all transmitted material.