# ENTYVIO® Infusion

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

## Prescriber Information

**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: ______________ ) **Prior infusion reactions:** ______________

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

**Prior treatments & reason for discontinuation:** ________________________________________

________________________________________________

**Date of *negative* TB test:** ________ or ☐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*:** ☐OptiMed Infusion Center ☐Home Infusion* ☐OptiMed 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.<br><br>☐**Other Dosing:** ______________________________.<br>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 OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide administrative nursing services and supplies in conjunction with the therapy prescribed above.

**Signature:** ______________________________ **Date:** ______________



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