KAISER PERMANENTE®

Kaiser Permanente Washington Home Infusion Pharmacy (KPWAHIP)
Vedolizumab (Entyvio) Prescription Referral Form
Phone: (206) 326-2990 **Fax Referral To: (206) 326-2139**

1 PATIENT INFORMATION

Patient Name: ______________________________
Phone: ______________________________
Address: ______________________________
City:______________**State:**__________**Zip:**______________
MRN #: ____________________
DOB: ____________________
Drug Allergies: ______________________________

2 PRESCRIBER INFORMATION

Prescriber's Name: ______________________________
DEA#: ______________**NPI:** ______________
Clinic/Facility Name: ______________________________
Address: ______________________________
City: ______________**State:** ______**ZIP:** __________
Phone: ______________**Fax:** ______________

3 Instructions to Provider

All orders with ✓ will be placed unless otherwise noted. Please fax completed order form to 206-326-2139. For drug prior authorization, call 1-888-767-4670 or visit https://wa-provider.kaiserpermanente.org/provider-manual/clinical-review/preservice

4 CLINICAL INFORMATION

Diagnosis (ICD-10 code): ______________________ **Date of Last Dose:** ______________________

5 ENTYVIO MAINTENANCE PRESCRIPTION INFORMATION

Vedolizumab (Entyvio)

Route: Intravenous
Weight: ________kg **Date Recorded:** ____________

First Dose: □ No □ Yes
Dose: □ 300 mg □ Other ____
Refills: □ 11 months □ Other ____
□ **Initial:** Start on week 0, 2, and 6 weeks, then continue every 8 weeks thereafter
□**Maintenance:** Continue every ____ weeks there after
Infusion Access: □ PIV □ CVAD □ Other: ____________________
Patient's Current Home Care/Specialty Pharmacy: ______________________________

Infusion Reaction Medications & Supplies

- ✓ **Hydrocortisone sodium succinate injectable 100 mg IV**
  Sig: Once PRN for hypersensitivity
- ✓ **Epinephrine AutoInjector** ? 0.15mg ? 0.3mg **QTY**: 2
  Sig: Inject into lateral thigh muscle for severe allergic reaction. Seek medical attention after use.
- ✓ **Diphenhydramine injectable 25 mg IV**
  Sig: Once PRN, may repeat x1 for urticaria, pruritis, shortness of breath
- ✓ **Sodium Chloride 0.9% IV 250 mL Bag**
  Sig: Once PRN for anaphylaxis
- ✓ **Sodium Chloride 0.9% IV Flush**: Flush 10 ml IV before/after medication administration or as needed for line maintenance. Then flush with 30 ml IV after medication administration.

Labs /Special Instructions/Pre-Meds: ______________________________
____
____
____

Infusion Protocol:
- Infuse per manufacturer guidelines
- Monitor vital signs (Temp, BP, HR, RR) every 15 minutes x 4; then every 30 minutes x2; then every 60 minutes until completion of infusion
- Documentation must include:
  - Start and end time of infusion
  - All rate changes, vital signs, including initial and final set
  - Patient response
- Observe patient for signs of infusion rate-related adverse reactions:
  - Blood pressure changes, increased pulse rate
  - Fever, chills
  - Headache
  - Chest, back or hip pain
  - Dyspnea
  - Mild erythema

6 PHYSICIAN SIGNATURE REQUIRED

X	X
SUBSTITUTION PERMITTED *(Date)*	DISPENSE AS WRITTEN (Date)

CONFIDENTIALITY NOTICE: This message and any attached files might contain confidential information protected by federal and state law. The information is intended only for the use of the individual(s) or entities originally named as addressees. The improper disclosure of such information may be subject to civil or criminal penalties. If this message reached you in error, please contact the sender and destroy this message. Disclosing, copying, forwarding, or distributing the information by unauthorized individuals or entities is strictly prohibited by law.
Members with Medicare Part B or D coverage are not required to use this form.