Entyvio® vedolizumab

Horizon Infusions

Location

☐ Liverpool
☐ New Hartford

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to (315) 457-4305
Phone (315) 457-3091

1. PATIENT INFORMATION

Name:	DOB:
Phone:	Other Phone:
Email:	
Social Security #:	Allergies:
Gender: ☐ M ☐ F	Weight: ☐ Lbs ☐ Kg

Patient Status: ☐ New to therapy ☐ Continuing therapy ☐ Next due date *(if applicable)*:

2. INSURANCE INFORMATION (*required*)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name:		NPI#:
License #:	TIN#:	DEA#:
Address:		
City:		State Zip
Office Contact:		Email:
Office phone:		Office fax:

4 . DIAGNOSIS INFORMATION (ICD 10 Code *Required*)

☐ Ulcerative Colitis (_____)
☐ Crohn's Disease (_____)
☐ Other: _____

5. PRESCRIPTION INFORMATION (*requires new order every 12 months*)

Frequency

☐ Induction: 300mg IV week 0, 2, 6, and then every 8 weeks

☐ Maintenance: 300mg IV every 8 weeks / ☐ Other: _____

☐ Pen Administration Loading Dose: 300mg IV Week 0, Week 2

☐ Vital signs per HI protocol
☐ Anaphylaxis & Hydration Management per HI protocol

PRE-MEDICATIONS ☐ N/A

☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg
☐ Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)
☐ Diphenhydrimine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV (requires driver)
☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 80mg ☐ 125mg IV
☐ Prednisone _____ mg PO
☐ Other _____

POST-MEDICATIONS ☐ N/A

☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg
☐ Prednisone _____ mg PO
☐ Other _____

6. LABS

☐ CBC w/Diff	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ CRP	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ CMP	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ ESR	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ Hepatic Panel	☐ Each Infusion	☐ Other Frequency (*specify*): _____
☐ Renal Panel	☐ Each Infusion	☐ Other Frequency (*specify*): _____

☐ Quantiferon TB Gold, annually, last completed *(date)*: _____

Other (*specify*):_____

7. SIGNATURE (required)

_____ _____

PHYSICIAN'S SIGNATURE DATE