HOME INFUSION OPTIONS PH:800.996.0978 | FX: 800.430.2202

Pediatric Crohn's or Ulcerative Colitis Order

Patient Name:_____

DOB: _____ Phone:_____

*** Include a facesheet with demographics and insurance information ***

DIAGNOSIS: _____ ICD-10: _____

*** Include an H&P, clinical notes and recent labs to support diagnosis ***

Clinical Assessment

◯ Patient is new to therapy Week 0,2,6 and every 8 weeks thereafter

◯ Patient is currently on Therapy

Start Date:_____

Last Infusion Date: _____

Current Weight: _____ kg / lbs

TB Test Results and Date: _____

Hep B Test Results and Date: _____

Other therapies Tried and Failed (Please list):

_____

_____

◯ Unresponsive to Conventional Treatment

◯ Inadequate Response to Methotrexate (Dose:_____)

◯ **Requested labs and Frequency Order:**

_____

_____

_____

◯ **No labs ordered**

Prescription Information

◯ **ENTYVIO (vedolizumab)**

_____ DOSE

_____ FREQUENCY

_____ REFILLS

◯ **REMICADE** ◯ **INFLECTRA** ◯ **May Substitute Biosimilar**

_____ mg/kg *weight based*

_____ mg *flat-dose*

_____ FREQUENCY

_____ REFILLS

◯ **SKILLED NURSING** - PER ADMINISTRATION

PRE-MEDICATION - 30 min prior to administration

Acetaminophen (Tylenol) ◯ 15 mg/kg ◯ _____

Diphenhydramine ◯ 1 mg/kg ◯ 2 mg/kg

◯ ORAL ◯ IVP

Solu-Medrol ◯ 1 mg/kg IVP ◯ 2 mg/kg IVP

Other: _____

Allergies:_____

Infusion supplies and Ambulatory Infusion Pump (E0780) are authorized to be dispensed per pharmacy protocol and medication administration guidelines. Hypersensitivity / Anaphylaxis Reaction per pharmacy protocol (reverse)

ORDERING PROVIDER

Signature:_____ Date: _____

Provider: _____ NPI: _____

Phone: _____ Fax: _____