



PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION	
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ Allergies: _____		Prescriber Name: _____ State License: _____ NPI #: _____ Tax ID: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Office Contact: _____ Phone: _____	
INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)			
Primary Insurance: _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____		Secondary Insurance (If Applicable): _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____	
CLINICAL INFORMATION			
<input type="checkbox"/> K51.919 Ulcerative colitis, unspecified with unspecified complications <input type="checkbox"/> K50.90 Crohn's disease, unspecified without complications <input type="checkbox"/> Other ICD-10 code (Please Specify Diagnosis): _____ Has patient received a TB test? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Date: _____ Line Access: <input type="checkbox"/> PIV <input type="checkbox"/> Port <input type="checkbox"/> PICC <input type="checkbox"/> Midline ** Obtain the following labs at prior to start of treatment and at _____ frequency: <input type="checkbox"/> CBC <input type="checkbox"/> CMP <input type="checkbox"/> CRP <input type="checkbox"/> ESR <input type="checkbox"/> LFTs <input type="checkbox"/> X-Ray <input type="checkbox"/> Other: _____			
ENTYVIO® ORDERS			
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____			
Medication	Dose/Frequency		Refills
<input type="checkbox"/> Entyvio® (vedolizumab)	<input type="checkbox"/> Loading Dose: Infuse 300mg intravenously at weeks 0, 2, and 6 <input type="checkbox"/> Maintenance Dose: Infuse 300mg intravenously every 8 weeks. <input type="checkbox"/> Other: _____		<input type="checkbox"/> Loading Dose: 3 doses <input type="checkbox"/> Maintenance Dose refills: _____
Pre-Medication	Dose/Strength	Directions	
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> 500mg <input type="checkbox"/> _____mg	<input type="checkbox"/> Take by mouth prior to each infusion	
<input type="checkbox"/> Cetirizine	<input type="checkbox"/> 10mg	<input type="checkbox"/> Take by mouth prior to each infusion	
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> 25mg <input type="checkbox"/> 50mg	<input type="checkbox"/> Take by mouth prior to each infusion <input type="checkbox"/> Administer via IV prior to each infusion	
<input type="checkbox"/> Methylprednisolone	<input type="checkbox"/> 40mg <input type="checkbox"/> 100mg <input type="checkbox"/> 125mg	<input type="checkbox"/> Administer methylprednisolone IV prior to each infusion	
<input type="checkbox"/> Ondansetron ODT	<input type="checkbox"/> 4mg	<input type="checkbox"/> Take by mouth prior to each infusion or as directed	
<input type="checkbox"/> _____	_____	_____	
ANAPHYLACTIC REACTION (AR):			
<input type="checkbox"/> EpiPen® Auto-injector 0.3 mg (1:1000) Inject IM -or- SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins x 1 if necessary <input type="checkbox"/> EpiPen Jr® Auto-injector 0.15mg (1:2000) Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg); may repeat in 3-5 mins x 1 if necessary <input type="checkbox"/> Diphenhydramine 50mg (1mL) - Administer 50 mg VIA slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary <input type="checkbox"/> Methylprednisolone 40mg - administer 40 mg IVP -or- IM if no IV access <input type="checkbox"/> Sodium Chloride 0.9% 500 mL infuse IV at a rate of up to 999 mL/hr			

CONFIDENTIALITY STATEMENT: This facsimile and documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender at the address and telephone number set forth herein and arrange for return or destruction of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.

**Please Fax Completed Form To: 888-898-9113**

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

☐ Other: _____**SIGNATURE**

We hereby authorize Valustar to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X _____

Prescriber Signature

Date: _____

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

CONFIDENTIALITY STATEMENT: This facsimile and documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender at the address and telephone number set forth herein and arrange for return or destruction of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.