FLEXCARE INFUSION CENTERS

Fax: (888) 219-8102 | **Email:** orders@flexcareinfusion.com | **Visit:** flexcareinfusion.com/referrals

ENTYVIO REFERRAL FORM

PATIENT DEMOGRAPHICS:

PATIENT NAME:	PATIENT'S CONTACT #:
DATE OF REFERRAL:	ADDRESS:
DATE OF BIRTH:	CITY, STATE, ZIP:
FOR COPAY ASSISTANCE, PLEASE PROVIDE LAST 4 OF SSN:	
HEIGHT: _____ FEET _____ INCHES	GENDER: FEMALE ☐ MALE ☐
WEIGHT: _____ LB or _____ KG	ALLERGIES: SEE LIST ☐ NKDA ☐

PRIMARY DIAGNOSIS:

- ☐ K51.00 Ulcerative (chronic) pancolitis without complications
- ☐ K51.20 Ulcerative (chronic) proctitis without complications
- ☐ K51.30 Ulcerative (chronic) rectosigmoiditis without complications
- ☐ K51.50 Left sided colitis without complications
- ☐ K51.80 Other ulcerative colitis without complications
- ☐ K51.90 Ulcerative colitis, unspecified, without complications
- ☐ K50.00 Crohn's disease of small intestine without complications
- ☐ K50.10 Crohn's disease of large intestine without complications
- ☐ K50.80 Crohn's disease of both small and large intestine without complications
- ☐ K50.90 Crohn's disease, unspecified, without complications
- ☐ Other

REQUIRED DOCUMENTATION: Please provide a copy of the following documents.

☑ 1. INSURANCE CARD (Front & Back) ☑ 2. PATIENT DEMOGRAPHICS ☑ 3. MOST RECENT LABS ☑ 4. MEDICATION LIST
☑ 5. H & P ☑ 6. TRIED/FAILED THERAPIES ☑ 7. NEGATIVE TB TEST RESULT

PRIMARY MEDICATION ORDER:

Please include MEDICATION, DOSE, FREQUENCY, DURATION and any ADDITIONAL administration INSTRUCTIONS specific to the primary therapy.

☐ Entyvio 300mg IV at weeks 0, 2, 6, and every 8 weeks thereafter.

☐ Entyvio 300mg IV every _____ weeks.

☐ Other:

FIRST DOSE: ☐ Y ☐ N

☑ Refill x12 months unless otherwise noted.

PRN & PREMEDICATIONS:

MEDICATIONS	30 minutes prior to every infusion	PRN
Acetaminophen 650 mg PO	☐	PRN every ___ hour for mild or moderate infusion reaction.
Diphenhydramine 25 mg PO	☐	PRN every ___ hour for mild or moderate infusion reaction.
Diphenhydramine 25 mg IV	☐	PRN every ___ hour for mild or moderate infusion reaction.
Methylprednisolone 125 mg IV	☐	PRN every ___ hour for mild or moderate infusion reaction.
Other: _____	☐	PRN every ___ hour for mild or moderate infusion reaction.

LINE USE/CARE ORDERS:

- ☑ START PIV/ACCESS CVC
- ☑ FLUSH DEVICE PER FLEXCARE INFUSION POLICY & PROCEDURE (SEE REVERSE SIDE)
- ☐ OTHER FLUSH ORDERS: (please fax other reaction orders if checking this box)

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

- ☑ ADMINISTER ACUTE INFUSION AND ANAPHYLAXIS MEDICATIONS PER FLEXCARE INFUSION POLICY AND PROCEDURE (See Reverse Side)
- ☐ OTHER: (please fax other reaction orders if checking this box)

PRESCRIBER INFORMATION: Please check preferred form of communication.

PROVIDER NAME:	PHONE:
OFFICE CONTACT:	☐ FAX:
ADDRESS:	☐ EMAIL:
CITY, STATE, ZIP:	NPI:

→ (GENERIC SUBSTITUTION PERMITTED)
PROVIDER SIGNATURE: DATE:

→ (DISPENSE AS WRITTEN)
PROVIDER SIGNATURE: DATE:

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FLEXCARE INFUSION CENTER'S ACUTE & ANAPHYLAXIS MEDICATION PROTOCOL:

**This table does not reflect non-medicinal interventions that are part of FlexCare's protocol, such as slowing or stopping the infusion and physician/911 notification.*

	MILD INFUSION REACTION	MODERATE INFUSION REACTION	SEVERE INFUSION REACTION/ANAPHYLAXIS
SYMPTOM CLASSIFICATION	• Flushing • Dizziness • Headache • Apprehension • Diaphoresis • Palpitations • Nausea / Vomiting • Pruitis	• Chest Tightness • Shortness of Breath • Hypo/hypertension (>20 mmHg Change in Systolic BP from Baseline) • Increased Temperature (>2 Degrees Fahrenheit • Urticaria	• Hypo/hypertension (>40 mmHg Change in Systolic BP from Baseline). • Increase Temperature (>2 Degrees Farenheit) with Rigors • Shortness of Breath with Wheezing • Laryngeal Edema • Chest Pain • Hypoxemia
TREATMENT PROTOCOL FOR ADULTS >66LBS	☒ Administer PRN medications per Physician order	☒ Administer PRN medications per Physician order	☒ Apply oxygen via ambu bag or high flow nasal canula, if vomiting. ☒ Administer 0.9% NaCl 500 mL at 125mL/hr to maintain IV access. ☒ Administer diphenhydramine 50 mg IV or IM Inject epinephrine 0.3mg/0.3 mL IM into the midanterolateral aspect of the thigh; repeat in 5-15 minutes if needed. ☒ Administer 0.9% NaCl 1000mL bolus for an incomplete response to IM epinephrine. May repeat x1.
TREATMENT PROTOCOL FOR CHILDREN 33LBS - 66 LBS	☒ Administer PRN medications per Physician order	☒ Administer PRN medications per Physician order	☒ Apply oxygen via ambu bag or high flow nasal canula, if vomiting. ☒ Administer 0.9% NaCl 500mL at 75mL/hr to maintain IV access. ☒ Administer diphenhydramine 1-2 mg/kg IM or slow IVP not to exceed 25mg/min ☒ Inject epinephrine 0.15mg/0.15 mL IM into the mid-anterolateral aspect of the thigh; repeat in 5-15 minutes if needed. ☒ Administer 0.9% naCl bolus 20mL/kg for an incomplete response to IM epinephrine. May repeat x1.

FOR CHILDREN < 33 LBS FLEXCARE INFUSION UTILIZES THE REACTION ORDERS OBTAINED BY THE REFERRING PHYSICIAN.

FLUSHING PROTOCOLS

		FLUSHING PROTOCOL Normal Saline*		LOCKING PROTOCOL Heparin Sodium		
		0.9% Sodium Chloride		*10 Units/mL*	*100 Units/mL*	
PATIENT CLASSIFICATION	LINE TYPE	PRE-ADMIN	POST ADMIN	POST LAB DRAW	POST NS FLUSH*	
ADULT > 66 LBS	Peripheral IV Catheter	3 mL	3 mL		3 mL	
	Midline	3 mL	3 mL		3 mL	
	Implanted Port	5 mL	10 mL	10 mL		5 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	10 mL	10 mL	5 mL	
	Tunneled & non-Tunneled Catheters	5 mL	10 mL	10 mL	5 mL	
PEDIATRIC 33 LBS - 66 LBS	Peripheral IV Catheter	3 mL	3 mL		3 mL	
	Midline	3 mL	3 mL		3 mL	
	Implanted Port	5 mL	5 mL	10 mL	3 mL	
	Peripherally Inserted Central Catheters (PICC)	5 mL	5 mL	10 mL	3 mL	
	Tunneled & non-Tunneled Catheters	5 mL	5 mL	10 mL	3 mL	

FOR CHILDREN <33 LBS, FLEXCARE INFUSION UTILIZES THE FLUSHING ORDERS OBTAINED BY THE REFERRING PHYSICIAN.

**0.9% NS will be substituted with Dextrose 5% or alternative only when indicated due to medication incompatibility with NS.*