Please fax both pages of completed form to your team at 808.650.6487.

To reach your team, call toll-free 808.650.6488.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

Entyvio® (vedolizumab)

accredo®
677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient

Patient's first name _____ Last name _____ Middle initial _____

Preferred patient first name _____ Preferred patient last name _____

Sex at birth: ☐ Male ☐ Female Gender identity _____ Pronouns _____ Last 4 digits of SSN _____

Date of birth _____ Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ Email address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ Email address _____

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other If other, please specify _____

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Office/clinic/institution name _____

Prescriber info: Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____ Office contact email _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion location: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site If infusion site, complete information below dotted line:

Infusion info: Infusion site name _____ Clinic/hospital affiliation _____

Site street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion site contact _____ Phone _____ Fax _____ Email _____

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____ Has the patient been treated previously for this condition? ☐ Yes ☐ No

Is patient currently on therapy? ☐ Yes ☐ No Please list all therapies tried/failed: _____

Patient wt _____ Date wt obtained _____

☐ NKDA ☐ Known drug allergies _____

Concurrent meds _____

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

INFUSION LOCATION: ☐ Patient's home ☐ Healthcare facility

Medication	Strength/Formulation	Directions	Quantity/Refills
☐ Entyvio® (vedolizumab)	300mg single dose vial	**For patients on Intravenous infusion for Loading and Maintenance dose** **Loading dose:** ☐ Infuse 300mg intravenously at week 0, 2, 6 and then every 8 weeks thereafter. **Maintenance dose:** ☐ Infuse 300mg intravenously every 8 weeks.	**Loading dose:** QS for 3 doses No refills **Maintenance dose:** 8-week supply. Refill x 1 year unless noted otherwise. ☐ _____ week supply Refills _____
	OR		
	300mg single dose vial	**For patients switching from Intravenous to subcutaneous, maintenance dose to start at week 6 or after 2 or more intravenous infusions** **Loading dose:** ☐ Infuse 300mg intravenously at week 0, 2 and then inject 108mg under the skin every 2 weeks starting week 6.	**Loading dose:** QS for 2 doses No refills
	108mg/0.68ml Single dose pen	**Maintenance dose:** ☐ Inject 108mg under the skin every 2 weeks.	☐ 1-month Supply ☐ 3-month Supply ☐ Other _____ Refills _____

Required medication and supplies for home infusion (please complete this section for home infusions only)

Premedication orders: ☐ Acetaminophen 650mg PO 30 min prior to infusion
☐ Diphenhydramine 50mg PO 30 min prior to infusion
☐ Other _____

Send quantity and refills sufficient for medication days supply.

Infusion method: Gravity (Pediatric patients will be given a pump unless noted otherwise)

Fluids for administration and reconstitution (please strike through if not required)
Fluid options should be as follows: NS 0.9% 250mL
Sterile Water as needed for reconstitution
NS 0.9% 50mL. Use 30mL for post infusion flush
NS 0.9% Flush (if central venous access, sterile flush will be provided)
Choose administration access: ☐ Peripheral access ☐ Central venous access
If central venous access: Flush with 10mL Sterile NS 0.9% before and after infusion ☐ Follow with heparin 100units/mL 5mL final flush
If peripheral access: Flush with 3mL NS 0.9% before and after infusion and as needed

Hypersensitivity/Anaphylaxis
Stop infusion
Medicate with:
Epinephrine/EpiPen 0.3mg IM as needed for anaphylaxis (for children less than 30kg: Epinephrine 0.15mg)
☐ Start NS 0.9% 100mL at TKO ☐ Diphenhydramine 50mg slow IVP PRN anaphylaxis
☐ Hydrocortisone 100mg slow IVP PRN anaphylaxis
☐ Solu-Medrol 125mg slow IVP PRN anaphylaxis ☐ Diphenhydramine 50mg PO PRN anaphylaxis
☐ Other _____

☐ Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy.
If nursing services will be required for therapy administration, the home health nurse may call for additional orders per state regulations.

Lab orders _____

Frequency _____

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.
If shipped to physician's office, physician accepts on behalf of patient for administration in office.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

_____ **Date** _____ **Dispense as written** _____ **Date** _____ **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc.
Non-compliance with state-specific requirements could result in outreach to the prescriber.