



GREATER BOSTON INFUSION CENTER

17/19 Kendrick St, Wrentham, MA 02093

P 774-581-0032 | F 774-581-0033

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Entyvio - Referral Checklist

Referral packet checklist

Complete this page and attach the supporting items below.

PATIENT & REFERRING PROVIDER

PATIENT NAME

DOB

DATE

REFERRING PROVIDER

NPI

DIRECT CONTACT / EXT.

OFFICE / PRACTICE

PHONE

FAX

EMAIL

URGENT CLINICAL CONTACT

REQUIRED REFERRAL PACKET

- ☐ Patient demographics and contact information
- ☐ Primary and secondary insurance information; front/back card copies
- ☐ Supporting clinical notes / office visits documenting Entyvio treatment plan
- ☐ Current medication list and allergies
- ☐ Relevant laboratory results / imaging and baseline safety information
- ☐ Completed Entyvio prescribing order (following page)

MEDICATION-SPECIFIC CLINICAL DOCUMENTATION

- Note should include any therapies tried/failed, and must include discussion about Entyvio
- Medication list and allergies
- Recommended: baseline LFTs and LFT continued monitoring q6months during treatment
- Recommended: negative TB screening

GBIC INTERNAL USE

REFERRAL RECEIVED

BENEFITS VERIFIED

PA STATUS / THROUGH

SCHEDULED



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Prescribing Order - Entyvio (vedolizumab)

☐ New Start

☐ Maintenance

DATE OF LAST DOSE / INFUSION

ORDER DETAILS

DATE OF ORDER

PATIENT NAME

DOB

M/F

DIAGNOSIS / ICD-10

☐ NKDA

PATIENT WEIGHT

ALLERGIES

PREMEDICATIONS

☐ Acetaminophen 1000mg PO

☐ Diphenhydramine 25mg IV

☐ Loratadine 10mg or Cetirizine 10mg PO

☐ Solu-medrol 125mg IV

☐ Diphenhydramine 25mg PO

☐ Other

LAB ORDERS

☐ CBC w/diff, CMP every

☐ LFTs every

☐ Other



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Prescribing Order - Entyvio (vedolizumab) (continued)

ENTYVIO MEDICATION ORDER

Dosing: ☐ Entyvio (vedolizumab) 300mg IV

Frequency: ☐ Dose at week 0, 2, and 6 ☐ Maintenance dose every
weeks

ADMINISTRATION & MONITORING

- ✓ Reconstitute Entyvio with sterile water and dilute in 250ml Normal Saline. Administer intravenously over 30 min
- ✓ Do not administer if patient has active signs or symptoms of infection.
- ✓ Do not administer if patient has new or worsening neurological signs and symptoms.
- ✓ In case of infusion reaction, STOP infusion and follow GBiC infusion reaction protocol. Notify physician.
- ✓ Signature Date

PROVIDER AUTHORIZATION

ORDERING PROVIDER NAME

NPI

DATE

SIGNATURE

OFFICE PHONE / EXT.

Handwritten or compliant electronic signature