

TO BE COMPLETED BY PHYSICIAN: Patient Name: W. Heater DOB: 6/25/65

Date Written: 1/30/20 Date of Administration: _____

Diagnosis: Cxns TNM Stage: _____

Protocol / Regimen - Entyvio 300mg IV

Height: 5' 8" in Weight: 200 kg

Body Surface Area (m²): _____

Emollic Level: ☐ Minimal ☐ Moderate ☐ High

Various Access: ☐ Peripheral ☒ Central

Lab Orders: ☐ CBC/DIFF ☐ BMP ☐ Magnesium ☐ UA

Held Parameters: ANC less than: _____ WBC less than: _____ PLT less than: _____ Hgb/Hct less than: _____ Scr greater than: _____

Non-chemotherapy orders: _____

IV Fluids: NS @ KVO (20 mL/hr) ☐

Solution, volume and infusion rate are per manufacturer/hospital guidelines unless otherwise specified. Chemotherapy agents will be rounded down to nearest vial size if within 5% of calculated dose. Biological agents will be rounded down to the nearest vial size if within 10% of calculated dose. Please administer chemotherapy in sequence listed below.

Chemotherapy	Dose per Unit (m ² , kg, AUC)	Dose Reduction (mg/m ² , AUC)	Calculated Dose	Dose Dispensed (Rounding to by RPH)	Route	Infusion Rate	RPH / Nurse Initials
Entyvio	300mg		300mg		IV		

IF using a dose reduction, please provide rationale:

MD Name (Print) Dr. Ellis MD Signature _____ Date/Time 1/30/20

RN Name (Print) Ciera A. RN Signature _____ Date/Time 1/30/20

RPH Name (Print) _____ RPH Signature _____ Date/Time _____

Physician Orders/Blank Chemotherapy Orders-2-1/Pharmacy 1-13

N = 20

CHEMOTHERAPY ORDERS

ORANGE REGIONAL MEDICAL CENTER

Jan. 30. 2020 9:25AM

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No. 8465

P. 1/2

P. 1/2

Wesley Heater 6/25/65

Entyvio Patient Assistance Program
Phone: 855-868-9846
Fax: 877-488-6814

January 10, 2020

Attn: David Ellis

30 Hatfield Ln

Ste 103

Goshen, NY 10924

Re: 1-2962281989

Dear David Ellis

We are pleased to notify you that your patient, Wesley Heater, qualifies to receive Entyvio through the Entyvio Patient Assistance Program. The program provides Entyvio at no cost to patients who meet the program's eligibility criteria. Program eligibility is reviewed periodically and may change if the patient no longer meets current program eligibility requirements.

NEXT STEPS: The Entyvio PAB Pharmacy will reach out to you (or the specified infusion site) to coordinate shipment of the patient's Entyvio prescription. This process will continue throughout the program term, which is until December 31st, 2020.

PLEASE NOTE: Patients receiving Entyvio through the Entyvio PAB should be infused only with product dispensed by the Entyvio PAB Pharmacy for the individual patient. The Entyvio PAB does not provide replacement product. To coordinate shipment of Entyvio for this patient, please call 1-(855)-368-9846. Please ensure that all infusion locations are aware of this patient's enrollment into the Entyvio PAB and follow the steps outlined here to obtain Entyvio through the program.

We have notified the patient of his or her approval to receive medication through the Entyvio Patient Assistance Program. If you have any questions, please do not hesitate to contact us at 1-(855)-368-9846. Case Managers are available to assist you Monday through Friday between 8 AM and 8 PM Eastern Standard Time.

Notes: No third party or patient can be charged for Entyvio provided under this program, and no product supplied hereunder can be sold, traded, or distributed for sale.

Sincerely,
Entyvio Patient Assistance Program

CC: Wesley Heater

Updated 2/23/2018

8/18/28 16:29:18 Fax Services

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HFMG 8452942312 >>

No. 8465

Page 002

P 2/2

Jan. 30. 2020 9:25AM
2020-01-30 09:17