

(vedolizumab

ENTYVIO infusion orders

Date: _____

Patient Name _____ DOB _____

Phone _____

M ☐ F ☐
☐ Allergies

NPI _____ Tax ID _____

Insurance Carrier (primary) _____

REFERRAL STATUS

Insurance Carrier (secondary) _____

- ☐ New Prescription
- ☐ Order Renewal
- ☐ Dose or Frequency Change
- ☐ Discontinuation

DIAGNOSIS Please provide ICD-10 code

☐ _____ Ulcerative Colitis

☐ _____ Crohn's Disease

☐ _____ (other)

PRE-MEDICATION

☐ Tylenol 1000mg PO

☐ Diphenhydramine 25mg PO

☐ Cetirizine 10mg PO

☐ _____ (other)

☐ Solu-Medrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

☐ _____ (other)

ENTYVIO ORDERS

DOSAGE

- ☒ 300mg IV
- ☐ Other _____

FREQUENCY

- ☐ Dose at weeks 0, 2, and 6, then every 8 weeks
- ☐ Dose every _____ weeks

PATIENT WEIGHT

_____ lbs.

_____ kg

ROUTE

☐ IV
Total dosage ☐ /refills

NOTES

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____