Patient Name:_____

DOB:_____ Wt(kg):_____

Allergies:_____ Phone:_____

Entyvio (Vedolizumab)
Infusion Orders

Required Information:

- ☐ Signed order from prescribing provider
- ☐ Patient demographics including insurance information
- ☐ Supporting clinical documentation: Visit notes, diagnostic results

Primary Diagnosis:

- ☐ Crohn's Disease (ICD-10 :_____)
- ☐ Ulcerative Colitis (IDC-10:_____)
- ☐ Other:_____(ICD-10:_____)

ENTYVIO ORDERS

☐ Induction Dose: Entyvio 300mg at weeks 0,2,6 then every 8 weeks

☐ Maintenance Doses: Entyvio 300mg every 8 weeks

Date of Last Entyvio:_____

Administered per manufacturer guidelines

PRE-MEDICATIONS

☐ PO Tylenol _____mg

☐ PO Cetirizine _____mg

☐ IV Solu-medrol _____mg

☐ PO Loratadine _____mg

☐ PO ☐ IV Diphenhydramine _____mg

☐ PO ☐ IV Other:_____ _____mg

LABS

☐ CBC ☐ ESR ☐ Uric Acid

☐ CMP ☐ TB Quantiferon Gold ☐ Other:_____

☐ CRP ☐ Hep B Core/Surface AG ☐ Other:_____

Frequency:

- ☐ Every Visit
- ☐ Every Other Visit
- ☐ One time only
- ☐ Other:_____

CPL Acct #:_____

ADDITIONAL INSTUCTIONS

Please include accommodations to be made for the patient, catheter care, prn orders, etc.

_____

_____

_____

Physician Name:	**Phone:**	**Fax:**
Physician Signature:	**NPI:**	**Date:**