(vedolizumab)

ENTYVIO infusion orders

Patient Name ______________________________ DOB ____________

Phone ______________________________ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

- ☐ ____________ Ulcerative Colitis
- ☐ ____________ Crohn's Disease
- ☐ ______________________ *(other)*

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ ______________________ *(other)*
- ☐ Length of Need ____________
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ ______________________ *(other)*

ENTYVIO ORDERS

DOSAGE

300mg IV

FREQUENCY

- ○ Dose at weeks 0,2, and 6, then every 8 weeks
- ○ Dose every ________ weeks

Refills: ____________

PATIENT WEIGHT

________ lbs.

________ kg

Notes

____

ORDERING PROVIDER

Signature **X** ______________________________ Date ____________

Provider ____________________ Phone ____________ Fax ____________

Address ____

____

NPI# ____________________

DEA# ____________________

FAX ORDERS: 702-780-4887