SPECIALTY INFUSION CENTERS

ENTYVIO ORDER FORM
(Vedolizumab)

FAX TO: 800-540-1852

PATIENT INFORMATION

Patient Name: ________________________ DOB: ________________ Phone: ________________ Sex: M / F

Ht: ______ WT: ______ lbs / kg Primary Language: ________________ Allergies: ________________________

Patient Preferred Location: ☐ Staten Island ☐ West Harrison ☐ Manhattan ☐ New Paltz ☐ Bronx ☐ Syosset ☐ Port Jefferson ☐ Millburn ☐ Brooklyn Heights ☐ Paramus

DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

ICD 10 Code (PROVIDE COMPLETE CODE)

☐ K50. _______

☐ K51. _______

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

NOTE: Exercise caution when considering the use of Entyvio in patients with a history of recurring severe infections. Consider screening for tuberculosis (TB) according to the local practice.

PRESCRIPTION

Pre-Medications

☐ Tylenol 650mg PO
☐ Zyrtec 10mg PO
☐ Claritin 10mg PO
☐ Benadryl 25mg PO
☐ Benadryl 25mg IVP
☐ Benadryl 50mg PO
☐ Benadryl 50mg IVP
☐ Pepcid 20mg PO
☐ Pepcid 20mg IVP
☐ Solu-medrol 125mg IVP
☐ Solu-medrol 250mg IVP
☐ Solu-medrol 500mg IVP

Other: ____________________

Pre Labs:

☐ CBC
☐ CMP
☐ CRP
☐ ESR
☐ Iron Panel
☐ Vitamin D
☐ Other ________________

Entyvio (Vedolizumab)

Loading Dose:

☐ IV: Infuse 300 mg at weeks 0, 2, 6

Maintenance Dose: (SELECT ONE)

☐ IV: Infuse 300 mg every 8 weeks for one year
☐ IV: Infuse 300 mg every _______ weeks for one year

In the event of an adverse reaction at a Specialty Infusion center, the adverse reaction protocol will be utilized.

Comments: ____

PRESCRIBER INFORMATION

Prescriber Name: ________________________________ Signature:

Supervising Provider (if applicable) ____________________________

Date: ____________ NPI#: ________________________ Specialty: ________________________

Practice Name: ____ (If Applicable)

Address: ____________________________ City: ______________ State: ________ Zip: ________

Contact Name: ____________________ Phone: __________ Fax: __________ Email: ________________