Infusion for Health
77 Rolling Oaks Drive, Suite 201
Thousand Oaks, CA 91361
Phone: 805-719-3700 Fax: 805-852-2636

ENTYVIO ORDER
(Vedolizumab)

****Please fax a copy of patient's <u>demographics, insurance information, current lab results including TB results, H&P relevant to the diagnosis and current medications</u>***

Date: ____/____/____

Patient Name: ____ **DOB:** ____/____/____

Allergies: ____ **Wt:** ________ **lbs / kg** **Ht:**__________

Diagnosis: ______________________________________ **ICD-10:** ___________________________

TB test date: _________________________ **Results:** ____________________

PRE-MEDICATIONS:
(Usually not indicated)

Benadryl	☐ **PO**	☐ **IV**	☐ **25mg**	☐ **50mg**	☐ **Pre med**	☐ **PRN**
Acetaminophen	☐ **PO**		☐ **650mg**		☐ **Pre med**	☐ **PRN**

Other OTC:_________________________________

Entyvio (Vedolizumab) IV Dosage:
300 mg / 250 mL 0.9% NS

Frequency: ☐ **Initial dose at 0,2,6 weeks, <u>then</u>** ☐ **q 8 weeks**

Other: _________________________ **Duration:** __________________

Start Date of Infusion: _____/_____/_____

Printed Provider's Name: ____ **NPI:** ____________________

Provider's Signature: ____ **Date:**_____/_____/_____

Office phone number: _____________________________ **Office Fax:**____________________________

Office address: ____**Contact person:** __________________