Phone: (805) 719-3700
Fax: (805) 413- 9099
Website: infusionforhealth.com

ENTYVIO ORDER
(Vedolizumab)

Please fax a copy of patient's:

- □ **Demographics**
- □ **Current Lab Results**
- □ **Medication List**
- □ **Copy of Insurance Cards**
- □ **TB Labs**
- □ **H & P Relevant to the Diagnosis**

Date: ____/____/____

Patient Name: _____ DOB: ____/____/____

Allergies: _____ Wt: _____ lbs / kg Ht:_____

Diagnosis: _____ ICD-10: _____

TB test date: _____ Results: _____

PRE-MEDICATIONS:
(Usually not indicated) **Diphenhydramine ☐25 mg ☐50 mg ☐PO ☐IV ☐Pre-med ☐PRN**
Acetaminophen ☐650 mg ☐PO ☐Pre-med ☐PRN
Other OTC:_____

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

Frequency: ☐ Initial dose at 0, 2, 6 weeks, then ☐ 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: _____