Entyvio Order
(Vedolizumab)

INFUSION FOR HEALTH

Ph: 805-719-3700 | Fax: 805-852-2636

Date: ___/___/___ Treatment Location: _____

***Please fax a copy of the following patient information:** ☐ Demographics ☐ Insurance Information ☐ Current Lab Results ☐ H & P Relevant to the Diagnosis ☐ TB Labs ☐ Current Medications

PATIENT INFORMATION

Patient Name: _____

DOB: ___/___/___

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: ___/___/___

Phone: (___) ___-____ Fax: (___) ___-____

Office Address: _____

Contact Person: _____

TB TEST

Result: _____ Test Date: ___/___/___ ☐ Copy Attached

PRE-MEDICATIONS: (USUALLY NOT INDICATED)

Diphenhydramine:	☐ 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, **then** ☐ q 8 weeks

Other: _____ Duration: _____

Start Date of Infusion: ___/___/___