Entyvio Order Form
(vedolizumab)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE)

☐ K50.0 _____ Crohn's Disease, Small Intestine
☐ K50.1 _____ Crohn's Disease, Large Intestine
☐ K50.8 _____ Crohn's Disease, Small & Large Intestine
☐ K50.9 _____ Crohn's Disease, Unspecified
Other: _____

☐ K51.8 _____ Other Ulcerative Colitis, Chronic
☐ K51.5. _____ Left Sided - Ulcerative Colitis, Chronic
☐ K51.0. _____ Universal Ulcerative Pancolitis, Chronic
☐ K51.9 _____ Ulcerative Colitis, Unspecified

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.**

LAB RESULTS: **Include Negative TB within 12 months.**

PRESCRIPTION

Pre-Medications
☐ Acetaminophen: 650 mg PO
☐ Cetirizine: 10 mg PO
☐ Diphenhydramine: 25 mg PO
☐ Diphenhydramine: 25 mg IVP
☐ Famotidine: 20 mg PO
☐ Methylprednisolone: 125 mg SIVP
Other: _____

Lab Orders+
Required: Negative TB, annually

+Medix Infusion will draw maintenance labs unless otherwise directed by Referring Provider

ENTYVIO (vedolizumab)

Loading Dose
☐ **IV:** Infuse 300 mg in 250 mL of 0.9% Sodium Chloride over at least 30 minutes at weeks 0, 2, 6

Maintenance Dose (SELECT ONE)
☐ **IV:** Infuse 300 mg in 250 mL of 0.9% Sodium Chloride over at least 30 minutes every 8 weeks for one year
☐ **IV:** Infuse 300 mg in 250 mL of 0.9% Sdoium Chloride over at least 30 minutes every _____ weeks for one year

Following each infusion, flush with 30 mL 0.9% Sodium Chloride

Post Treatment Observations: The patient is observed for 30 minutes following the first administration.

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

Comments:

_____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____