

Vedolizumab (Entyvio)

Provider Order Form rev. 1/23/2025

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____ Patient Phone: _____
Patient Address: _____ Patient Email: _____
Allergies: _____ NKDA Weight (lbs/kg): _____ Height (in/cm): _____
Sex: M / F Date of Last Infusion: _____ Next Due Date: _____ Preferred Location: _____

DIAGNOSIS (Please provide ICD-10 code in space provided)

K50. ____: Crohn's Disease K51. ____: Ulcerative Colitis
 Other: _____ Description: _____

THERAPY ADMINISTRATION & DOSING

Entyvio 300mg IV in 250ml NS over a period of 30mins, flush with 30ml NS.

FREQUENCY (Choose one)

Induction: week 0, 2, 6, and then every 8 wks
 Maintenance: every 8 weeks
 Every ____ weeks

ADDITIONAL ORDERS

LABORATORY ORDERS

CBC at each dose every: _____
 CMP at each dose every: _____
 LFT at each dose every: _____
 Other: _____

PRE-MEDICATION ORDERS

Tylenol 500mg / 650mg PO
 Loratadine 10mg PO
 Pepcid 20mg PO / IVP
 Benadryl 25mg / 50mg PO / IVP
 Solumedrol 40mg / 125mg IVP
 Other: _____

NURSING

Hold infusion and notify provider for:

- abnormal vital signs, signs/symptoms of illness or active infection
- New onset fatigue, anorexia, abdominal pain, dark urine, or jaundice
- planned/recent surgical procedures
- neurological changes
- Recent live vaccines

Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: _____ Preferred Contact Email: _____
Ordering Provider: _____ Provider NPI: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip Code: _____

REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, colonoscopy, history of fistula, history of hospitalization for bleeding

Required Labs: Negative TB within 12 months, CRP, ESR, fecal calprotectin, Negative hep B

Provider Name (print) _____

Provider Signature _____

Date _____

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.