Vedolizumab (Entyvio) Provider Order Form rev. 1/23/2025

PATIENT INFORMATION	Referral Status:	□ New Re	eferral \Box	Updated Ord	ler 🔲 Order Renewal
Patient Name:		DOB:		Patient Pho	ne:
Patient Address:	Patient Email:				
Allergies:		□ NKDA	Weight (I	os/kg):	Height (in/cm):
Sex: ☐ M / ☐ F Date of Last Infusion:	Next Due Date:		Preferre	ed Location:	
DIAGNOSIS (Please provide ICD-10 code in space	e provided)				
☐ K50: Crohn's Disease	□ K51: Ulc	erative Colit	is		
□ Other:	Description:				
THERAPY ADMINISTRATION & DOSING Entyvio 300mg IV in 250ml NS over a period of 3 with 30ml NS. FREQUENCY (Choose one) Induction: week 0, 2, 6, and then every 8 wks Maintenance: every 8 weeks Every weeks ADDITIONAL ORDERS CBC	Omins, flush	Solumedro Other: URSING Hold infusi	500mg / □ 10mg PO ng □ PO / □ 15mg / □ 25mg / □ 15mg / □	650mg PO IVP 50mg PO 125mg IVP fy provider for signs, signs/syr gue, anorexia, a surgical proceanges cines er Nursing Pron Management	: nptoms of illness or active abdominal pain, dark urine,
Preferred Contact Name:	Preferred Contact Email:				
Ordering Provider: Referring Practice Name:	Provider NPI: Phone: Fax			Fax:	
Practice Address:	City		Stat		Zip Code:
REQUIRED DOCUMENTATION CHECKLIST (•		uired for m	ocaccina and	•
Required Documentation: Patient demos, copy of treatment failures or contraindications, colonoscop Required Labs: Negative TB within 12 months, CRP,	front and back of pr y, history of fistula,	imary and s history of h	econdary ir ospitalizati	nsurance, 2 m	ost recent OVN including
Provider Name (print) Pr	ovider Signature				