VEDOLIZUMAB

(Entyvio)

Outpatient Infusion

Order Form

Patient Name	
DOB	
Address	
Phone	

Order Status	☐ New Order ☐ Renewal ☐ Dose or Frequency Change	
Allergies:		**Weight:** **Height:**
Diagnosis	☐ Crohn's Disease ☐ Ulcerative Colitis Other:	**Diagnosis Code:**
Required Information	Negative Quantiferon TB, T-spot or chest x-ray (no active disease)	Date:
	Diagnostic Hepatitis B panel	Date:
	Coccidioides Screen/Panel	Date:
	CBC and CMP	Date:

Required Documentation

- H&P or progress note supporting diagnosis
- Medication history
- Recent labs (as above) and/or diagnostic test results

Labs	☐ Hepatic Function panel every 3 months	☐ Other:

Pre-Medications

☐ Diphenhydramine ○ PO ○ IV ○ 25 mg ○ 50 mg ☐ Acetaminophen ○ 325 mg ○ 650 mg

☐ Other:

Entyvio (vedolizumab) IV Medication Order

☐ Entyvio (vedolizumab) IV 300 mg

- ☐ Induction: Week 0, 2, 6, then every _____ weeks thereafter
- ☐ Maintenance: Every _____ weeks

☐ Other:

Infusion Reaction Medications

Hypersensitivity Reaction Protocol will be utilized unless otherwise specified

Provider (print name):	Date:
Provider Signature:	NPI:
Office Phone:	Office Fax: