

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



(vedolizumab)

ENTYVIO

Infusion orders

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
<input type="checkbox"/> New Referral	<input type="checkbox"/> Referral Renewal
<input type="checkbox"/> Medication/Order Change	<input type="checkbox"/> Benefits Verification Only
<input type="checkbox"/> Discontinuation Order	

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: _____ Fax: _____
Practice Address:	City: _____ State: _____ Zip Code: _____

DIAGNOSIS *Please provide ICD-10 code*

_____ Ulcerative Colitis
 _____ Crohn's Disease

PRE-MEDICATION

Tylenol 1000mg PO Solu-Medrol 125mg IVP
 Diphenhydramine 25mg PO Solu-Cortef 100mg IVP
 Cetirizine 10mg PO Diphenhydramine 25mg IVP
 _____ (other) _____ (other)

SPECIAL INSTRUCTIONS

ENTYVIO ORDERS

DOSE:

300mg IV
 Other _____

FREQUENCY

Dose at weeks 0,2, and 6, then every 8 weeks
 Dose every _____

ROUTE

IV

TOTAL DOSES:

1 yr _____ Other _____ Refill _____
Route: SQ IV

PATIENT WEIGHT

_____ lbs.
_____ kg

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____