

Vermont
28 Park Ave
Suite #1A
Williston, VT 05495



(vedolizumab)

ENTYVIO

Infusion orders

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS

☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ 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 _____