

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 \_\_\_\_\_