ENTYVIO INFUSION ORDER
(vedolizumab)

Date: ____/____/_____

PATIENT INFORMATION

Patient Name:______________________ DOB:___/____/____ Phone: ________________________

Height: _____________ Weight _________ lbs / kg

Allergies: ____

Diagnosis: ____ ICD-10: ______________________

TB Test Date: _____/____/____ Result: _______ Hep B Test Date: _____/____/____ Result: _______

Labs to be drawn by: O Infusion Clinic O Referring Physician

Lab Orders: ____

PRE-MEDICATIONS

Diphenhydramine:	O PO	O IV	O 25mg	O 50mg	O PreMed	O PRN
Acetaminophen:	O PO		O 650mg		O PreMed	O PRN

ENTYVIO ORDERS

Dose: 300 mg / 250 mL 0.9% NS Frequency: O initial dose at 0, 2, 6 weeks , then O q 8 week

Other: ____

Infusion Start Date: _____/_____/_____

PROVIDER INFORMATION

Provider's Name: ____________________________ Signature: _____________________________

Phone: _______________________ Fax: _________________________ Date: _____/_____/______

Office Address: ____

Email Address: ______________________________ Contact Person: ________________________

PLEASE SEND COPY (FRONT AND BACK) OF INSURANCE CARD

PHONE: 972-810-0990 | FAX: 972-810-0994