

INFUSION ORDERS- ENTYVIO (VEDOLIZUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

*List of infusion center locations may be found at: <https://metroinfusioncenter.com/infusion-center-locations/>
 Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE	
<input type="checkbox"/> Moderate to Severe Ulcerative Colitis	ICD 10 Code: K51.90
<input type="checkbox"/> Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90
<input type="checkbox"/> Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION	
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> TB Test Results	<input type="checkbox"/> Baseline liver function tests <input type="checkbox"/> Clinical/Progress notes <input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> Vedolizumab level and antibody test results (if changing dose or frequency)
List Tried & Failed Therapies, including duration of treatment:	
1)	
2)	
3)	

MEDICATION ORDERS	
Initial Dosing	<input type="checkbox"/> Entyvio 300mg IV at Week 0, 2, 6 then Every 8 Weeks
Maintenance Dosing	<input type="checkbox"/> Entyvio 300mg IV Every 8 weeks
Alternative Dosing	<input type="checkbox"/> Entyvio 300mg IV Every _____ weeks
Refills:	<input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses

PREMEDICATIONS
<input type="checkbox"/> Acetaminophen 650mg PO prior to Entyvio infusion
<input type="checkbox"/> Diphenhydramine 25mg PO prior to Entyvio infusion
<input type="checkbox"/> Methylprednisolone 125mg Slow IV Push PRN infusion reaction
<input type="checkbox"/> Other:

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

Contact us with questions at: BioNurses@MetroInfusionCenter.com or call (877) 448-3627

Fax completed form and all documentation to (866) 507-1164

All information contained in this form is strictly confidential and will become part of the patient's medical record.