Vedolizumab (Entyvio)

Fax Form to: 330-294-2082

INDY INFUSION

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Provide nursing care , including reaction management and post-procedure observation

☑ TB status & date (list results here & attach clinicals)
_____

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

☑ **Vedolizumab** (Entyvio) in 250ml 0.9% sodium chloride or lactated ringer's, intravenous infusion
- Dose: ☑ 300mg
- Frequency: ☐ induction: week 0, 2, 6, and then every 8 wks
- ☐ maintenance: every 8 weeks / ☐ other:
_____
- Infuse over 30 minutes

☑ Flush with 0.9% sodium chloride at infusion completion

☐ Patient is required to stay for 30-minute observation
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

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*Exercise caution when considering the use of Entyvio in patients with a history of recurring severe infections. Consider screening for tuberculosis (TB) according to the local practice.

Provider Name (Print) **Provider Signature** **Date**

Please include the following information when submitting a referral for Entyvio:
-Results of a recent tuberculosis (TB) skin/lab testing
-Patient's current weight and height
-Clinicals to support one or more of the following:
-Patient has moderately to severely active Crohn's disease (CD)
-Patient has moderately to severely active ulcerative colitis (UC)