Fax your completed order to 877-734-1157

Patient Name: ________________________DOB: ____/___/________Date of Last Infusion: ______/___/________
Height___________Weight__________
Infusion Location: (state and site) _____________________________________

Entyvio® (vedolizumab) Infusion Orders

Diagnosis (please provide ICD-10 code in space provided):

_________Crohn's Disease (ICD-10)   _________Ulcerative Colitis (ICD-10)

_________Other: ____
(ICD-10)   (description)

- Hold infusion and notify provider for:
  - Abnormal vital signs or fever, signs/symptoms of illness or active infection
  - New onset fatigue, anorexia, abdominal pain, dark urine or jaundice
  - Planned/recent surgical procedures, neurological changes
  - Recent live vaccinations
- If an infusion-related reaction occurs, stop infusion, notify provider and follow Hypersensitivity Reaction Management Protocol as clinically indicated

Lab orders:

❑ CBC with diff	❑ CMP	❑ LFT	❑

Dosing:

Entyvio 300mg IV in 250ml NS over a period of 30mins, flush with 30ml NS

Frequency (chose one):

☐ On weeks 0, 2, 6, then every 8 weeks

☐ Every 8 weeks

☐ Every Additional__________weeks

Orders:

Provider Name (print) _________________________________Date:___________________________

Provider Signature: _______________________________________Time: ____________________________

Reviewed 6/29/2022. Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.