Vedolizumab (Entyvio)

Provider Order Form rev. 12/23/2021

AleraCare
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PATIENT INFORMATION

Patient Name: DOB:

☐ NKDA Allergies: Weight lbs/kg:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

ICD-10 Code

☐ K51.90 Moderate to severe ulcerative colitis
☐ K50.90 Moderate to severe Crohn's Disease

☐ Other:_____

MEDICATION ORDER

☑ **Vedolizumab** (Entyvio) in 250ml 0.9% sodium chloride or lactated ringer's, intravenous infusion
- ☑ 300mg
- Frequency: ☐ induction: week 0, 2, 6, and then every 8 weeks
- ☐ 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 post infusion/injection
☐ Patient is NOT required to stay for observation time
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.

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

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication ☐ History and Physical Report
☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)
☐ ANA (SLE) ☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months