

## ENTYVIO® (VEDOLIZUMAB) PRESCRIBER ORDER FORM

**FAX COMPLETED FORM, INSURANCE INFORMATION, CLINICAL DOCUMENTATION (LATEST NOTES & LABS) to: (757) 466-1128**

NEW PATIENT OR

CHANGE ORDER:  Drug Change  Dose Change  Interval Change

Patient Name:	Date of Birth:
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Phone:	Gender:
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Address:

Allergies:

Height:  in  cm

Weight:  lbs  kg

### CLINICAL INFORMATION

**Primary Diagnosis Description:**

**ICD-10 Code:**

**Is this the first dose?**  Yes

No – date of next dose due: \_\_\_\_\_

**Treatments Tried and Failed:**

### PRESCRIPTION

**ENTYVIO® (Vedolizumab) refill as directed x 1 year**

IV Regimen

Initial Dose: Infuse 300mg IV over at least 30 minutes on Weeks 0, 2, and 6.

Maintenance Dose: Infuse 300mg IV over at least 30 minutes every 8 weeks.

Other: \_\_\_\_\_

### ANCILLARY ORDERS

**Pre-Medication Orders:**

- Acetaminophen 650mg PO 30 minutes before infusion.
- Diphenhydramine 25mg PO/IV 30 minutes before infusion.
- Methylprednisolone Succinate 125mg IV push 20 minutes before infusion.
- Other: \_\_\_\_\_

**PRN Hypersensitivity Meds:**

- Epinephrine 0.3mg
- Solu-Cortef 100mg
- Solu-Medrol 125mg
- Diphenhydramine 25-50mg
- NS 500 ML (>30kg)

*I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.*

**Prescriber Signature:**

**Date:**

### PRESCRIBER INFORMATION

Prescriber Name:	Phone:	Fax:
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Address:	NPI:
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City, State, Zip:	Office Contact:
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