Infusion Associates
3230 Eagle Park NE, Suite 101
Grand Rapids, MI 49525
Phone: 616-954-0600 Fax: 616-954-1675

Entyvio IV Infusion ORDER

(vedolizumab)

*****Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications*

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:_____**

Diagnosis:_____

DX CODES: ***ICD-10*** : **_____, _____, _____**

TB verification ***(circle one):*** **TB skin test TB spot/Quantiferon blood test Chest X-RAY**
□ **COPY ATTACHED**

Result Date: _____/_____/_____ Result ***(circle one):*** **Positive Negative**

LABS to be drawn: □ CBC Lab Frequency**:** _____
□ CMP
□ **_____**

Pre- Medications:

(Not Indicated)			
	Diphenhydramine PO	25mg or 50mg	□Yes □ No
	Cetirizine PO	10mg	□Yes □ No
	Acetaminophen PO	650mg	□Yes □ No

Start Date of Infusion: _____/_____/_____ **Entyvio Infusion #** _____

Entyvio (vedolizumab) IV Dosage:
300 mg

Infuse over 30 mins

Frequency: □ **Initial Dose – 0, 2, 6wks THEN q 8 wks.** □ **q 8 weeks** □ **Other:_____**

Rx Expiration Date: _____/_____/_____

Printed Provider's Name: _____

Provider Signature: _____

Office Phone Number: _____Office Fax Number: _____