



Entyvio (vedolizumab) Order Form

Please include recent labs and last two office visit notes

Please fax to 907-746-7798 - Clinic Phone Number: 907-746-7771

PATIENT INFORMATION

Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Weight:
Patient Status: <input type="checkbox"/> New to therapy <input type="checkbox"/> Continuing therapy Next due date (if applicable):	

PHYSICIAN INFORMATION

Physician's Name:		NPI#:
License #:	TIN#:	DEA#:
Address:		
City:	State:	Zip:
Office phone:	Email:	
Office contact:	Office fax:	

DIAGNOSIS INFORMATION

<input type="checkbox"/> Ulcerative Colitis	ICD 10:	<input type="checkbox"/> Crohn's Disease	ICD 10:	Year of Diagnosis:
<input type="checkbox"/> Other:			ICD 10:	Year of Diagnosis:

INSURANCE INFORMATION

Please submit copies of the front and back or primary and secondary insurance cards with this referral.

Primary Insurance:	ID#	Secondary Insurance:	ID#
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PRESCRIPTION INFORMATION (requires new order every 12 months)

Medication may be substituted with payer-preferred brand, generic, or biosimilar equivalent per authorization and institutional formulary

Medication: Entyvio (vedolizumab)

☐ Initial ☐ Maintenance

☐ Loading Dose: 300mg IV at weeks
then 300mg every 8 weeks

☐ Maintenance Dose: 300mg IV
Every 8 weeks over 30 minutes

PRE-MEDICATIONS:

☐ N/A

☐ Acetaminophen: ☐ 500mg ☐ 650mg ☐ 1000mg PO

☐ Loratadine (Claritin): 10mg PO

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Dexamethasone: ☐ 5mg ☐ 10mg ☐ 20 mg IV

☐ Famotidine: ☐ 20 mg IV

POST-MEDICATIONS

☐ Acetaminophen: ☐ 500mg ☐ 650mg ☐ 1000mg PO

☐ Other orders:

Vital signs per clinic protocol

Infusion reaction/Hydration

Management per clinic protocol

Signature (required)

PHYSICIAN SIGNATURE

DATE