



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: Weight: Patient Status: 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

Ulcerative Colitis ICD 10: Crohn's ICD 10: Year of Diagnosis: Other: ICD 10: Year of Diagnosis:

INSURANCE INFORMATION

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

Primary Insurance: ID# Secondary Insurance: ID#

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 0, 2 and 6 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