Phone: (847) 324-6800 Fax: (224) 251-7141 Email: intake@infusacare.com

InfusaCare
MedFuse

Entyvio (Vedolizumab) Infusion Order

Patient Name: DOB: □ Male □ Female

Diagnosis (please provide ICD10 code):

□ Other:

□ NKDA □ Allergies:

□ New Therapy Order □ Continuation of Therapy Date of last dose:

Ordering Provider Name:

Provider NPI: Phone: Fax:

Practice Address: City: State: Zip Code:

Pre-Medication

□ Acetaminophen _____mg by □ PO
□ Ceterizine _____mg by □ PO
□ Diphenhydramine _____mg by □ PO/ □ IVP
□ Solu-Medrol _____mg by □ PO/ □ IVP
□ Solu-Cortef _____mg by □ PO/ □ IVP
□ Other:

Patient height and weight:

Patient Height (cm):

Patient Weight (kg):

Required Documentation:

□ Patient Demographics
□ Patient Insurance (med and pharm card copies, front and back)
□ Progress Notes/Labs supporting diagnosis
□ Baseline liver function test
□ Vedolizumab level and antibody test results (if changing dose/frequency)
□ Hepatitis B status and date
□ CBC, CMP, ESR, CRP lab results
□ Quantiferon/TB test results
□ Most recent colonoscopy (within one year)
□ Other:

Entyvio Medication Order (Please select ONE):

□ Induction dosing on weeks 0, 2 and 6, followed by maintenance
- ▪ Dosing (Please choose one)
  - □ 300mg
  - □ Other: _____
- ▪ Maintenance Frequency (Please choose one)
  - □ Every 8 weeks
  - □ Other: _____

□ Maintenance dosing every ____ weeks only
- ▪ Dosing (Please choose one)
  - □ 300mg
  - □ Other: _____

Additional Instructions/Notes:

Ordering Provider:

Signature: _____ Date: _____

Provider: _____ Phone: _____ Fax: _____

Best Contact Person in Office: _____ Phone: _____

Updated: 4/10/2024