

Vedolizumab (Entyvio)

Provider Order Form rev. 3/25/2022



PATIENT INFORMATION

Date:	Patient Name:	DOB:
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy	Next Due Date (if applicable):	

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

NURSING

- Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 09.07.2021)
- TB status and date (results) _____

LABORATORY ORDERS

- CBC at each dose every _____
- CMP at each dose every _____
- CRP at each dose every _____
- Other: _____

PRE-MEDICATION ORDERS

- acetaminophen (Tylenol) 500mg / 650mg / 1000mg PO
- cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- diphenhydramine (Benadryl) 25mg / 50mg PO / IV
- methylprednisolone (Solu-Medrol) 40mg / 125mg IV
- hydrocortisone (Solu-Cortef) 100mg IV
- Other: _____
Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

- Vedolizumab** (Entyvio) in 250ml 0.9% sodium chloride or lactated ringer's, intravenous infusion
 - 300mg
 - Frequency: induction: week 0, 2, 6, and then every 8 wks
 - maintenance: every 8 weeks / other: _____
 - Infuse over 30 minutes
- Flush with 0.9% sodium chloride at infusion completion
- Patient is required to stay for 30-minute observation post infusion/injection
- Patient is NOT required to stay for observation time
- Refills: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

*Exercise caution when considering the use of Entyvio in patients with a history of recurring severe infections. Consider screening for tuberculosis (TB) according to the local practice.

Provider Name (Print) _____ Provider Signature _____ Date _____

FAX NUMBERS

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> CHICAGO: 312-253-7244 | <input type="checkbox"/> INDIANAPOLIS: 844-983-2028 | <input type="checkbox"/> PHILADELPHIA: 844-820-9641 | <input type="checkbox"/> WEST TN/AR: 888-615-1445 |
| <input type="checkbox"/> COLUMBUS: 844-627-2675 | <input type="checkbox"/> JACKSONVILLE: 904-212-2338 | <input type="checkbox"/> RALEIGH: 919-287-2551 | <input type="checkbox"/> MIDDLE TN: 888-615-1445 |
| <input type="checkbox"/> BAY AREA: 844-889-0275 | <input type="checkbox"/> DAYTONA: 386-259-6096 | <input type="checkbox"/> KANSAS CITY: 844-900-1292 | <input type="checkbox"/> SARASOTA: 941-870-6550 |
| <input type="checkbox"/> CHARLOTTE: 336-663-0143 | <input type="checkbox"/> HARRISBURG: 844-859-4235 | <input type="checkbox"/> ORLANDO: 844-946-0867 | <input type="checkbox"/> SOUTHWEST FL: 813-283-9144 |
| <input type="checkbox"/> CINCINNATI: 844-946-0868 | <input type="checkbox"/> HARTFORD: 860-955-1532 | <input type="checkbox"/> PALM BEACH: 561-768-9044 | <input type="checkbox"/> TAMPA: 844-946-0849 |