

Vedolizumab (Entyvio)

Fax to 505-420-4848 or Email to refer@optimuminfusion.com



PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ DOB: _____

ICD-10 code (required): _____ ICD-10 description: _____

NKDA Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

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 Optimum Infusion Nursing Procedures, including reaction management and post-procedure observation.
- TB status & date (list results here & attach clinicals)

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
 - Dose: 300mg
 - Route: Intravenous infusion
 - Frequency: induction: week 0, 2, 6, and then every 8 weeks
 - maintenance: every 8 weeks / other: _____
- _____
- Infuse over 30 minutes
- Flush with 0.9% sodium chloride at infusion completion
- 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

SUBMIT ORDER FORM TO OPTIMUM INFUSION:
 FAX: 505-420-4848
 EMAIL: refer@optimuminfusion.com