VOA Multispecialty Infusion Clinic

(757) 271-0969 call
(757) 466-1128 fax

VEDOLIZUMAB (ENTYVIO®) PRESCRIBER ORDER FORM

FAX COMPLETED FORM, INSURANCE INFORMATION, CLINICAL DOCUMENTATION (LATEST NOTES & LABS) to (757) 466-1128

☐ **NEW PATIENT OR**

☐ **CHANGE ORDER:** ◯ **Drug Change** ◯ **Dose Change** ◯ **Interval Change**

Patient Name:	Phone:	Date of Birth:
Address:		
Allergies:		
Height: ☐ inches ☐ cm	Weight: ☐ lbs ☐ kg	

CLINICAL INFORMATION

Primary Diagnosis Description:	**ICD-10 Code**:

Is this the first dose? ☐ Yes

☐ No – date of next dose due: _____

Treatments Tried and Failed:

VEDOLIZUMAB (ENTYVIO®) PRESCRIPTION

Vedolizumab (ENTYVIO®) refill as directed x 1 year

IV Regimen

☐ Initial Dose; Infuse 300 mg IV over at least 30 minutes on Weeks 0, 2, and 6.

☐ Maintenance Dose; Infuse 300mg IV over at least 30 minutes every 8 weeks.

☐ Other: _____

ANCILLARY ORDERS

Pre-Medication Orders:

☐ Acetaminophen 650mg PO 30 minutes before infusion.

☐ Diphenhydramine 25mg PO/IV 30 minutes before infusion.

☐ Methylprednisolone Succinate 125mg IV push 20 minutes before infusion.

☐ Other: _____

PRN Hypersensitivity Meds:

- Epinephrine 0.3mg
- Solu-Cortef 100mg
- Solu-Medrol 125mg
- Diphenhydramine 25-50mg
- NS 500 ML (>30kg)

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: **Date:**

PRESCRIBER INFORMATION

Prescriber Name:	**Phone:**	**Fax:**
Address:		**NPI:**
City, State:	**Zip:**	**Office Contact:**