RED RIVER HEALTH
Ambulatory Infusion Clinic

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ENTYVIO (vedolizumab) Infusion Orders

Patient Name: _____ DOB: _____ ☐ M ☐ F

☐ NKDA Allergies: _____

☐ New Start therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

Ordering Provider: _____ Provider NPI: _____

Practice Phone: _____ Practice Fax: _____

Diagnosis *(please provide ICD-10 code)*:

☐ _____ Ulcerative Colitis (UC) ☐ _____Crohn's Disease (CD)

☐ _____ _____
(other)

Pre-Medication:

☐ Tylenol 1000mg PO ☐ Solu-Medrol 125mg IVP

☐ Cetirizine 10mg PO ☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg PO ☐ Diphenhydramine 25mg IVP

☐ Other: _____

Required Documents:

☑ Patient Demographic Sheet

☑ Clinical/Progress notes, labs, tests supporting primary diagnosis *(please attach)*

☐ TB Status and Date *(please attach)*
**Consider TB screening according to local practice*

ENTYVIO ORDERS:

Dosing: ☑ Mix in 250ml 0.9% sodium chloride, administer IV over 30 minutes

☐ 300mg IV ☐ Other: _____

Frequency: ☐ Dose at weeks 0, 2, and 6, then every 8 weeks ☐ Other: _____

☐ Maintenance dose every _____ weeks

Refills: _____ *(if not indicated, Rx will expire one year from date signed)*

Red River Health Standing Orders:

☑ Provide treatment under Red River Health's Biologic Therapy Policy and Adverse Reaction Management Protocol. **Copy can be provided per request.*

Ordering Provider Signature: _____ Date: _____