aleracare
advanced infusion centers™

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Entyvio (vedolizumab)

Provider Order Form rev. 5/5/2023

Patient Information

Patient Name: DOB:

Patient Phone: Patient Email:

◯ NKDA ◯ Allergies: Weight lbs/kg: Height:

Patient Status: ◯ New to Therapy ◯ Continuing Therapy ◯ Therapy Change Last infusion date (if applicable): _____

Is the patient pregnant, planning a pregnancy or nursing: ◯ Yes ◯ No Does the patient need interpreter services: ◯ Yes ◯ No

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

ICD-10 CODE

◯ K51.80 Ulcerative colitis

◯ K50.90 Crohn's disease, unspecified, without complications

◯ K50.10 Crohn's disease of large intestine without complications

◯ K51. 90 Ulcerative colitis, unspecified, without complications

◯ K50.00 Crohn's disease of small intestine without complications

◯ Other: _____

Medication Order

Entyvio (vedolizumab) **Dose:** ◯ 300mg IV over 30 min **Frequency:** ◯ week 0, 2, 6 and then every 8 weeks thereafter ◯ every 8 weeks

Documentation Required (Note: Send all labs, must include specific labs listed here)

◯ Labs (TB test) ◯ Insurance Card (front and back) ◯ Current Medications ◯ History/Progress Notes

Pre-Medication Order

acetaminophen (Tylenol) ◯ 500mg ◯ 650mg ◯ 1000mg PO

cetirizine (Zyrtec) ◯ 10mg PO

loratadine (Claritin) ◯ 10mg PO

diphenhydramine (Benadryl) ◯ 25mg ◯ 50mg / ◯ PO ◯ IV

methylprednisolone (Solu-Medrol) ◯ 40mg IV ◯ 125mg IV

hydrocortisone (Solu-Cortef) ◯ 100mg IV

Other: _____

Dose:_____ Route:_____ Frequency: _____

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

_____

_____ _____ _____

Provider Name **Provider Signature** **Date**

Order Expiration Date (mm/dd/yy): _____ (If not indicated order will expire one year from date signature) Check here if this is a stat order ◯