ENTYVIO (VEDOLIZUMAB) ORDER FORM

Patient Name:		DOB:
Mobile Number	Patient Weight: kg	Patient height: In
Allergies		

PROVIDER INFORMATION

Provider Name	Provider NPI:	
Signature:		Date:
Contact Name:	Phone:	Fax:

Prerequisites to treatment — ensure the following information is complete and attached with referral:

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

DIAGNOSIS (Provider must specify)

☐ Ulcerative Colitis, ICD 10: K51.

☐ Crohn's Disease, ICD 10: K50. Other:

PRE-MEDICATION

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Cetirizine 10 mg PO

☐ Methylprednisolone (Soil-I-Medrol) 125mg IV ☐ Benadryl 25mg PO

Other: Dose: Route:

Medication

Medication	Dose	Route	Frequency	Duration
ENTYVIO	300 mg	IV	☐ Week 0,2,6 them every 8 weeks ☐ Every 8 weeks	☐ 1 Year ☐ Or Refills:

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

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified
Please fax your order to one of the following locations.

One Care Infusion Pharmacy
2025 Chicago Ave, STE A3
Riverside, CA 92507
Ph: 951-900-1120
Fax: 951-900-1125

One Care Infusion Pharmacy
907 W Coal Ave
Gallup, NM 87301
Ph: 505-726-4155
Fax: 505-726-4304