Infusion for Health
77 Rolling Oaks Drive, Suite 201
Thousand Oaks, CA 91361
Phone: 805-719-3700 Fax: 805-852-2636

ENTYVIO ORDER
(Vedolizumab)

Please fax a copy of patient's demographics, insurance information, current lab results including TB results, H&P relevant to the diagnosis & Rx, and current medications.

Date: ____/____/____

Patient Name: _____ DOB: ____/____/____

Allergies: _____ Wt: _____ lbs / kg Ht:_____

Diagnosis: _____ ICD-10: _____

TB test date: _____ Results: _____

PRE-MEDICATIONS:
(Usually not indicated)

Benadryl	☐ **PO**	☒ **IV**	☒ **25mg**	☐ **50mg**	☐ **Pre med**	☐ **PRN**
Acetaminophen	☒ **PO**		☒ **650mg**		☐ **Pre med**	☐ **PRN**

Entyvio (Vedolizumab) IV Dosage:
300 mg / 250 mL 0.9% NS

Frequency: ☐ Initial dose at 0,2,6 weeks, then ☐ q 8 weeks

Other: _____ Duration: _____

Start Date of Infusion: _____/_____/_____

Printed Provider's Name: _____ NPI: _____

Provider's Signature: _____ Date:_____/_____/_____

Office phone number: _____ Office Fax:_____

Office address: _____Contact person: _____